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VOL. 88, NO. 1

Award-Winning Journal of the Michigan State Medical Society

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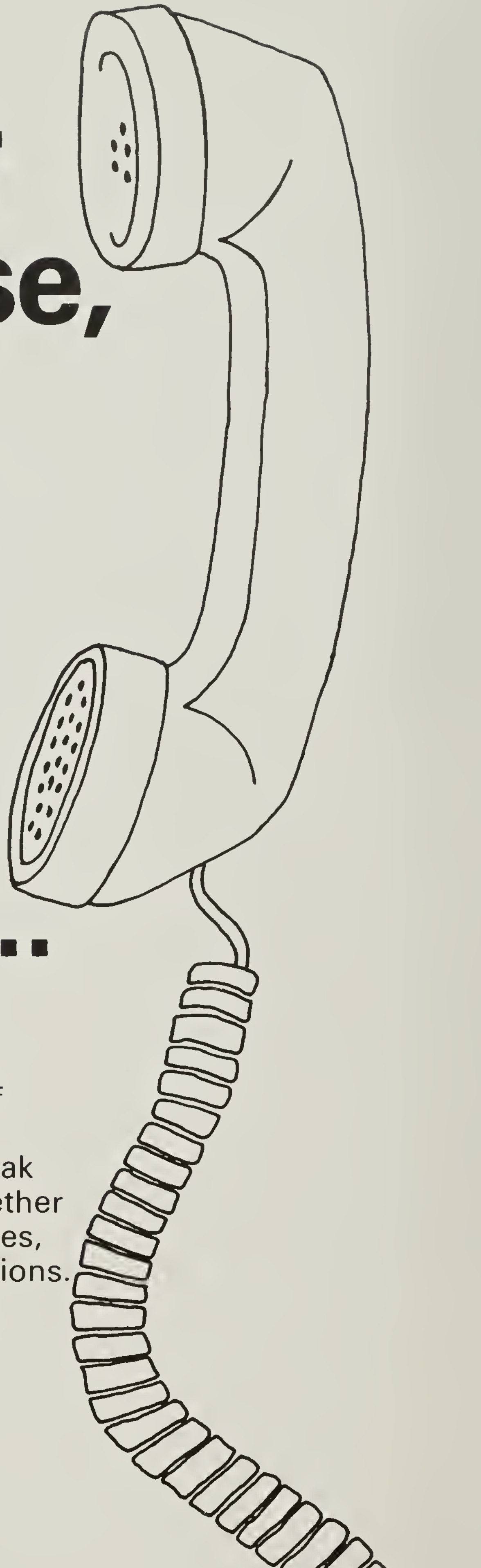

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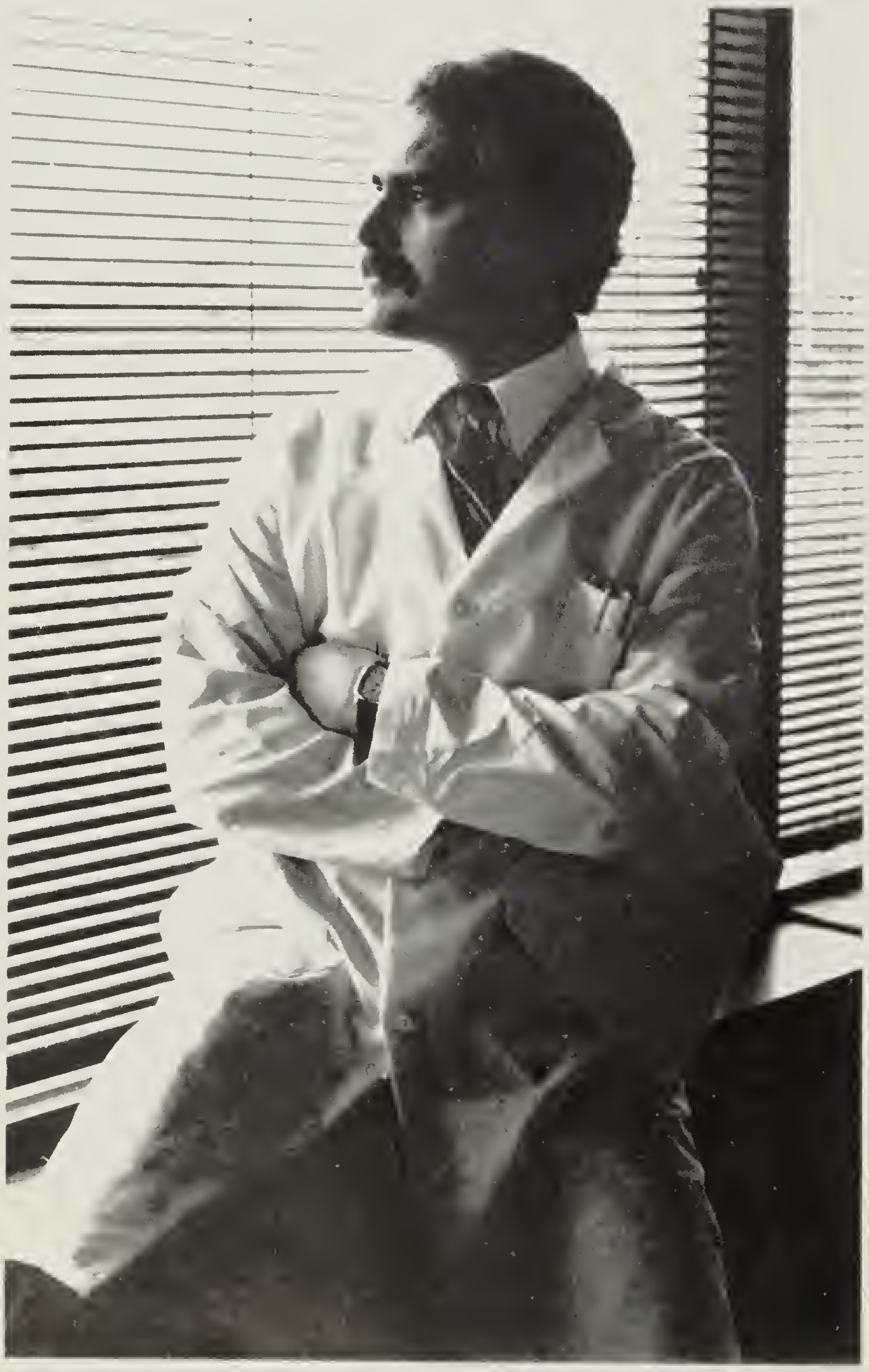

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MICHIGAN MEDICINE

Award-Winning Journal of the Michigan State Medical Society

JANUARY 1989
VOL. 88, NO. 1

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From front cover to President's page, this issue of Michigan Medicine is new. Illustrations play a large role. Typeface and paper stock are new. A variety of styles delineate cover stories, features and departments. Our purpose is to keep your journal fresh, informative and entertaining. We welcome your comments.

— Henry M. Domzalski, MD,
Chairman, MSMS Committee
on Publications

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Cover Story

"Perinatal Periscope: Looking Beyond the Horizon" is the theme of this year's Michigan Conference on Maternal and Perinatal Health slated for March 22-23 at the Hyatt Regency Dearborn. This month's cover story features a complete preliminary program and registration form for this not-to-be-missed event.

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Cover illustration by: *Robert L. Brent.*

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socioeconomics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranted by MSMS.

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IN MY OPINION

Physicians Recovery Network needs your financial support

By James L. Fenton, MD

Last summer MSMS Board Chairman Frank B. Walker, MD, asked me to accept a new assignment — to serve as chairman of the MSMS Steering Committee to Assist Impaired Physicians. My first reaction was to thank him for considering me, but to decline the invitation. After all, I knew little about the workings of the Steering Committee and felt that others were probably more qualified to fill the position.

However, Doctor Walker and MSMS Executive Director William E. Madigan urged me to give it a try. They told me I didn't need to know a lot about addictionology — that the medical director of the Physicians Recovery Network (PRN), Gerald A. Vandervoord, MD, and the members of the Steering Committee were the experts in that area and I could rely on them. But, the PRN had lost a major portion of its funding and important legislation needed to be enacted — that is what they wanted me to tackle. I accepted the challenge.

I soon began to learn about the scope of the program. Do you realize that PRN is continuously monitoring over 75 cases, and that the whole program includes over 250 recovering physicians? And, more cases are being opened each month as word about the program spreads and old misconceptions about the disease are broken down.

However, such a program is expensive. In addition to adequately compensating our medical director and support staff, the program requires promotional material, extensive travel, intervention expenses, educational programs on the disease, and so forth.

Because of our substantial loss of financial support, the Steering Committee declared funding of the PRN its first priority.

PICOM made a commitment in 1987 to provide a generous annual grant for two years. When we explained our current financial dilemma to them, the Board generously extended its financial support for another year. For that we sincerely thank PICOM.

We have contacted MPMLC, as well, and sanquinely anticipate it also will provide financial support. The Michigan Association of Osteopathic Physicians and Surgeons joined the PRN and has been making annual contributions to the program. MAOPS is being urged to increase its donation.

In addition, the PRN Subcommittee on Finance, headed by Justin L. Sleight, MD, (a long-time member of the Steering Committee and until recently, a member of the MSMS Board of Directors), has been given the assignment of seeking ongoing funding of the PRN through foundations, voluntary contributions from the membership, business grants, and other sources. In the meantime, I plan to exert what influence I have to urge MSMS to increase its funding of the PRN.

Our second priority, enactment of impaired physician legislation, is in part an extension of our first priority. One component of the proposed bill, which we hope will be introduced in 1989, provides ongoing funding to PRN for the services it would render in the state. Another component of this legislation which, according to MSMS Legal Counsel Richard Weber, makes it of critical importance to MSMS, is its immunity provision for those who work with the program. We plan to work closely with the MSMS Committee on State Licensure and Discipline toward early enactment of the legislation.

We have a lot of work cut out for us in 1989. Right now our impaired physician program is in dire financial straits and, therefore, is in jeopardy. We can't let this happen. What PRN is doing for our sick colleagues, the public, and the medical profession is too important.

I've tried to tell you in the space allowed what MSMS, the Steering Committee, and our supporters are doing to save PRN. At the same time, I've tried to express my personal commitment to the program.

Now, I'd like to turn to you, the members of MSMS, for help. Yes, we need money. Anything received will be greatly appreciated (any donations earmarked for PRN should be made payable to the Health Education Foundation). But we also need your ideas and input. I know many of you have served on fundraisers in your communities and are aware of innovative ways for soliticing funds. Share your knowledge with us. Just send your comments to: Physicians Recovery Network, Box 950, East Lansing, MI 48826-0950, and we'll pass them to on to Doctor Sleight and his Finance Subcommittee. ■

Doctor Fenton is a member of the MSMS Committee on Publications.

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Letters from Our Readers

Nancy Crandall thanks MSMS members

I would like to express my thanks to the many physicians throughout Michigan who supported my recent successful campaign for the state legislature. The response to my appeal for financial support was extremely gratifying and both (my husband) Don and I are very grateful.

I've also appreciated the many notes and messages received before and since the election. I now look forward to representing my district in state government and to working with and for the health care professions. I hope to see many of you during my term of office.

Nancy Crandall
Representative-Elect

Nancy Crandall, a Republican, was elected state representative from the 97th District Nov. 8.

MSMS receives thanks for participation in organ donor campaign

On behalf of all the awaiting recipients in the State of Michigan, as well as the Organ Procurement Agency of Michigan, we would like to thank you for your efforts to increase organ donors in Michigan. Hopefully, the "Break the Silence" campaign will encourage families to discuss organ donation and make the decision to donate their organs.

Our Board of Directors met the night of the press conference, and we showed the tape at the meeting. They were greatly impressed with it and hope it will be shown throughout the state.

We will distribute the brochure to everyone we can, as well as show the public service announcement to our medical and nursing staff when we in-service the hospitals in the state.

Again, we would like to thank you for this most important effort, as we look forward to working together in the future.

Gerda H. Lipcaman
Executive Director
Organ Procurement Agency of Michigan

Cynthia Giles-Holland, RN
Clinical Director
Organ Procurement Agency of Michigan

"Break the Silence," a statewide public service campaign by physicians, attorneys and hospitals, was launched October 19 at a joint press conference in Lansing.

Elements of the campaign include 30-second public service announcements for television and radio and a brochure discussing organ donation.

Physicians interested in distributing "Break the Silence" brochures may order them by writing to "Break the Silence," Department of Communications, Michigan State Medical Society, PO Box 950, East Lansing, MI 48826-0950. There is no charge to MSMS members for these brochures.

Tort system "woefully inadequate"

I have written a book entitled *Jury of My Peers: A Surgeon's Encounter with the Malpractice Crisis.* A factual account of my experience with a medical malpractice suit, the book explores not only my personal agony, but also the inadequacies of our current tort system for deciding medical liability claims — a problem which potentially affects every American.

It is my belief that almost all of society would be better off with a different system. Coincidentally and fortuitously, the message of my book closely parallels the proposal by the American Medical Association and the 31 specialty societies for removing malpractice from the jury system.

I firmly believe that in order for us to have a reasonable chance of achieving significant medical liability reform in this country, the people must be made aware that the current system is woefully inadequate to meet their needs.

I am contacting every state medical society in the country to solicit their help with this project which I believe is vital to the future of health care in this country.

My hope is that every state medical society will devote some space to the book in one of their monthly journals so that all doctors will be exposed to the message of the book. If enough doctors read it and then place a copy in their waiting rooms to expose patients to it, I believe we can have a significant impact upon public opinion.

For those interested in obtaining a copy of my book, please feel free to contact me at: Suite 410, Baptist Medical Tower, 2055 E. South Blvd., Montgomery, AL 36116, (205) 284-9580.

Howard C. Snider, MD
Montgomery, AL

RBRVS is not the most logical way to compensate physicians

William C. Hsiao, PhD, et al in the September 29, 1988 issue of *The New England Journal of Medicine* showed a more logical basis (than does the recently-released Harvard Relative Value Scale) for compensating physicians across various specialties. An absolute value scale for physician income may be much more fruitful. Physicians need to be able to articulate reasons to justify their incomes. The following analysis can be readily grasped by economists, businessmen and laymen.

I will use Hsaio's methods (simplified) to show the return that a high school graduate, expecting only normal profits, requires to rationalize the investment of going through premedicine, medical school and residency.

The marginal costs of becoming a physician include the opportunity costs of foregoing, let's say, the income of manual labor with good fringe benefits ($25,000 per year). To this we must add the expenses of going to school with tuition costs, insurance and of interest expenses of borrowing these funds (say $15,000 per year). Costs of living are not marginal and drop out of the equation. We must subtract earnings of being a resident, which approximate those of a good job. About 50 percent of freshmen never finish college and fewer than 50 percent of graduates desiring entry to medical school are successful. There is small salvage value in going through a pre-med curriculum; more relevant is the risk premium that our student demands on his hoped-for successful investment. This investment most closely resembles equity. Businessmen require a 15 percent return on equity.

Forty thousand dollars per year at 15 percent interest grows to $549,000 after eight years of school. At that point our student earns a living wage as a resident, but does not yet earn any return on his investment. If the residency lasts three years (for internal medicine or family practice), then his investment grows to $835,000. Amortizing this amount over a 40-year career requires an annual return of $125,000. He must demand $25,000 per year because he's working 40 hours each week. A net income of $150,000 plus adjustments for inflation rationalizes a medical education in the year 1988.

The above analysis is relevant only to current prospective students. This annual income is the market price necessary to attract resources into the medical profession.

The medical training of fully-trained physicians is a sunk cost. The investment has been made and is worth only salvage value or whatever profits it can still yield. Sagging numbers and quality of medical school applicants suggest that students perceive that current physician incomes are not returning what the market demands as a normal return on a risky business venture.

In the same issue of *The New England Journal of Medicine,* William L. Roper, MD, of the Health Care Financing Administration, ponders these relationships in the marketplace and appropriately worries about the supply side of his enterprise. He can lower physician fees in the short term, but may create long-term problems for his successors.

Erwin J. Haas, MD, MBA
Grand Rapids

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UM geriatrics center receives $980,000 grant for training programs

The University of Michigan Geriatrics Center will use a new $980,000 grant to help develop geriatric clinical care programs in communities across the state.

The three-year award — the only one of its kind in Michigan — was provided by the W.K.Kellogg Foundation in Battle Creek.

The grant will be used to train physicians, nurses and social workers in geriatric care, said Jeffrey B. Halter, MD, chief, Division of Geriatric Medicine, UM Medical School, and director, UM Geriatrics Center.

For more information or to apply for the training programs, write to Jeffrey B. Halter, MD, UM Geriatrics Center, Turner Building, 1010 Wall St., Ann Arbor, MI 48109-0714, or call Doctor Halter at (313) 763-4002.

ACS approves cancer program at Beaumont Hospital

William Beaumont Hospital, Royal Oak, has three-year approval for its cancer program from the Commission on Cancer of the American College of Surgeons. Only 20 percent of the nation's hospitals receive such approval.

Cancer program approval is granted to a hospital only after the Commission completes an extensive evaluation not only of the program itself, but also of all the functions and departments supporting it.

An integral part of an accredited hospital's cancer program is the tumor registry. Beaumont's tumor registry, accredited since 1977, began more than 30 years ago when the hospital opened.

Harper Hospital's new "laser balloon" receives FDA approval

Harper Hospital recently announced that its new "laser balloon" is approved by the US Food and Drug Adminstration for a major international cooperative heart trial. The "laser balloon" is being developed at Harper Hospital by J. Richard Spears, MD, director, cardiac laser laboratory, Harper Hospital, and associate professor of medicine, Wayne State University School of Medicine.

The balloon angioplasty procedure uses laser energy and has shown great promise in treating patients with narrowed or blocked coronary arteries in recent clinical trials.

The Spears Laser Balloon radiates an umbrella of diffuse laser energy from the inflated balloon to smooth and remold the artery open. It is hoped that this unique device will reduce the potential for tissue damage in arteries — risks that have limited the application of other experimental laser angioplasty techniques.

Medical interest in the laser balloon is high because the new device may be beneficial in

continued on next page

Physicians in the News

Stan Alfred, MD, makes his way to Hollywood

By Chad B. Munger

For some people, the road to Hollywood will never be more than a dream. For others, like Stan Alfred, MD, a Flint dermatologist, the road is only a classified ad away.

Doctor Alfred's answer to a classified ad eventually led him to a stint as temporary medical consultant to Lifetime Television. His eagerness and ability to communicate are what have put Doctor Alfred's name in network credits.

Communication between physicians and the public is something that Doctor Alfred would like to see more of.

"Doctors are educators as well as healers and soothers of the sick and infirm," he says. "As physicians, we all communicate and educate in our daily routines. But communicating for the masses is something we all need to do more of."

Fifteen years as a practicing dermatologist and 13 months bedridden by a chronic back problem have shown Doctor Alfred both sides of the story. They have convinced him that in most cases the physician/patient relationship leaves something to be desired. He has decided to do something about it.

His mission to change the physician/patient relationship and his subsequent trek into the limelight began with the publishing of a number of papers on herpes (Doctor Alfred is a specialist in syphilology).

In 1982, the year his first papers appeared, herpes was thought of much like AIDS was just a few short years ago. No one yet thought of it as epidemic.

His written book attracted the attention of two talk shows, Detroit's "Kelly and Company," and national cable television show "Telling Secrets with Sonya Friedman." Appearances on these programs generated letters from 46 states and convinced Doctor Alfred that television

could be a powerful tool. "Television is a tremendous untapped resource for educating the public on medical matters," he says.

Though television was what got his foot in the door, Doctor Alfred decided to find his audience through the airwaves first. "I think I'm more relaxed (when on the radio)," he says.

He approached local Flint station WFDF about creating a new medical education program. What he found was that "We were welcomed by the people at WFDF. They know their audience is very interested in medical matters, that there is a tremendous thirst for medical knowledge in the Genesee area."

"Doctor's House Call" is the product of their collaboration. For 90 minutes every week listeners may call in and pose questions for Doctor Alfred and a special guest on subjects from orthopedics to medical economics. "Doctor's House Call," which first aired in 1984, is now in its 200th show.

With the radio program firmly entrenched and enjoying a great deal of success, it was time to tackle television once again. This time, "Channel 5 House Calls" was the result. For five minutes a week, Doctor Alfred questions a specialist on a show which reaches over 250,000 mid-Michigan homes.

The lights of LA were in his future. As a representative to the AMA's Television and Radio Health Reporting Conferences in 1984 and 1986, Doctor Alfred became aquainted with some of the biggest names in medical media, including George Straight of

continued on next page

Stan Alfred continued

ABC News and Doctor Art Ulene, NBC's *Today* show family physician.

In late 1987, Doctor Ulene placed an ad in the *Journal of the American Medical Association (JAMA)*, looking for help writing a book on cholesterol. As Doctor Alfred modestly states, "I answered and he picked me out of the applicants."

In January of 1988, the doctor arrived in California. In keeping with its reputation, California seemed again to be heading in a new direction — this time in medicine. "The people are the same everywhere you go, but I see a tremendous push for preventive medicine out there, a push toward providing information that could not be shared in a hurried office setting," Doctor Alfred says.

His initial responsibility was research for Doctor Ulene's book, *Count Out Cholesterol*, which will be published later this year. Doctor Alfred also was assigned to answer some of the more difficult questions Doctor Ulene received in response to his segment on *Today*.

Videotape presentations on back problems for General Motors and compiling a list of the "best" books to read on a given health question also were part of Doctor Alfred's responsibilities. His work during the three-month period garnered an offer from Doctor Ulene and his staff to serve as temporary medical consultant to Lifetime Television.

"It was a real eye-opener, seeing the way these people put together a show," says Doctor Alfred. His new duties were to come up with the ideas for shows, write scripts, coordinate experts and work with producers and directors to pull off a show.

"Physicians Journal Update," the program Doctor Alfred was responsible for, has featured several Michigan physicians, including MSMS member Joel Saper, MD, Ann Arbor. The show is considered one of the premier medical education programs on television.

Doctor Alfred sees the potential for quality medical programing in Michigan. "It's important for patients to gain information from informed physicians," he concluded.

News Fronts continued

shrinking arterial clots that are responsible for the vast majority of spontaneous and sometimes life-threatening heart attacks. Exploration continues as to whether this could be an added remedy for limiting heart attacks.

Kellogg Eye Center part of national glaucoma treatment study

The University of Michigan's W. K. Kellogg Eye Center will participate in a nationwide study to determine the most effective method of preventing blindness caused by glaucoma.

The multimillion dollar, five-year Advanced Glaucoma Intervention Study, sponsored by the National Eye Institute, Bethesda, MD, is the first large-scale, long-term research project into the treatment of advanced glaucoma.

Researchers throughout the United States are beginning to screen 840 study participants to test the benefits of incisional surgery and laser surgery in treating glaucoma patients.

"This is a very important study," said Gregory L. Skuta, MD, assistant professor of ophthalmology, UM Medical Center, and co-investigator in the study. It will give us crucial information about glaucoma therapies that will allow us to provide patients with the best possible treatment if surgery is required."

Approximately two million adults in the United States suffer from glaucoma — thousands of whom risk blindness without appropriate detection and treatment.

Detroit Receiving is now a Level I Trauma Center

Detroit Receiving Hospital and University Health Center is now verified by the American College of Surgeons as a national Level I Trauma Center, the highest level any emergency/trauma health facility can attain.

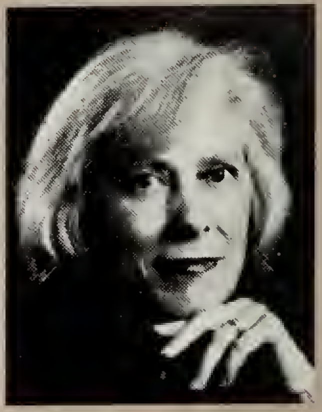
The College of Surgeons, which officially announced the Detroit Receiving designation last September, acknowledged the institution's historical leadership in trauma care, education,

continued on next page

Physicians in the News

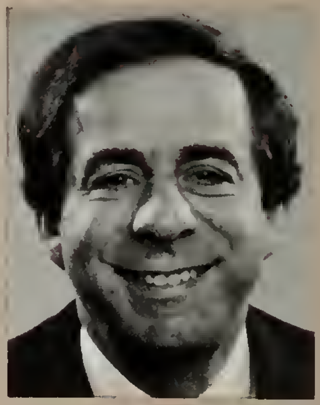
William E. Powers, MD, Detroit, chief, Gershenson Radiation Oncology Center, Harper Hospital, and chairman, Department of Radiation Oncology, Wayne State University School of Medicine, is recipient of the gold medal of the American Society for Therapeutic Radiology and Oncology (ASTRO). The ASTRO gold medal is the most prestigious honor given to a member whose contributions and service in the field of radiation oncology have been outstanding.

Nathan Brooks, MD, West Bloomfield, is the recipient of the 1988 Ellen G. Martin Award for Humanitarian Service. Presented yearly by the Board of Trustees of Hutzel Hospital, the award honors individuals for outstanding service to both the hospital and the community. Doctor Brooks, who specializes in cardiology and pulmonary medicine, was honored for his lifelong commitment to Hutzel and the Detroit community. A graduate of the Wayne State University School of Medicine, Doctor Brooks is celebrating his fiftieth year as a practicing physician. He is assistant chief of medicine, Hutzel Hospital, and a clinical professor, Wayne State University School of Medicine.



Elizabeth A. Hutchinson, MD Lansing dermatologist, is the new president of the Michigan Dermatologic Society. She was installed at the organization's 24th annual meeting.

Robert J. Sokol, MD, Bloomfield Hills, is one of the top obstetrician-gynecologists in the United States, according to the October 1988 issue of *Good Housekeeping*. Doctor Sokol is the interim dean of the Wayne State University School of Medicine and professor, chairman, and chief of obstetrics and gynecology at Wayne State University and Hutzel Hospital.



Terry M. Silver, MD, Ann Arbor, professor and associate chairman, Department of Radiology, University of Michigan, is a new member of the Board of Governors of the American Institute of Ultrasound in Medicine (AIUM). He will serve a three-year term. The AIUM is an 8,000-member international medical specialty society devoted to the advancement of the art and science of ultrasound in medicine and research.

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Continued from page 10

Physicians in the News

James G. Fordyce, MD, Dearborn, a member of the medical staff at Oakwood Hospital, continues on the board of directors of the 2,000-member American Lung Association of Southeast Michigan. An allergy and clinical immunology specialist at Oakwood Hospital and the Dearborn Allergy and Asthma Clinic, Doctor Fordyce will serve on the ALASEM board through September 1991.

Roy T. Bergman, MD, an Escanaba general surgeon, is a new appointee to the Michigan Council on Physical Fitness & Health. He also has received gubernatorial appointment to the Great Lakes State Sports Commission.

Lyle Sensenbrenner, MD, Grosse Pointe, associate director, hematology, and director, bone marrow transplant program, Harper Hospital, is recipient of the Michigan Science Trailblazer Award. The award is presented by the Detroit Science Center in cooperation with the Michigan Sesquicentennial Commission to honor selected individuals — born, educated or employed in Michigan — who have greatly contributed to the quality of life for mankind. Doctor Senenbrenner is considered to be a leading authority on bone marrow transplantation.

Jeffrey D. Band, MD, Huntington Woods, director of epidemiology and chief, Division of Infectious Disease, William Beaumont Hospital, is a new member of the Board of Trustees of the Society of Hospital Epidemiologists of America. The purpose of the society is to develop and promote policies to reduce the incidence of infections developed during hospitalization.

Thomas L. Schwenk, MD, Ann Arbor, is the new chairman, Department of Family Practice, University of Michigan Medical School. Doctor Schwenk, a UM associate professor of family practice, has served as interim chairman for the department since 1986 and chief of service since 1985.

Derrick T. Britt, MD, medical director, North Avenue Women's Center, Battle Creek, is a new member of the Board of Directors of the Visiting Nurses Services of Southern Michigan Inc.

Harold E. Bowman, MD, Lansing, professor and associate chairperson of pathology, Michigan State University College of Human Medicine, is the College of American Pathologists' nominee to serve on the Diagnostic and Therapeutic Technology Assessment Program of the American Medical Association. This program draws on a panel of selected physicians to respond to questions regarding the safety and effectiveness of drugs, devices, procedures or techniques used in medical practice.

News Fronts continued

and research in southeastern Michigan.

"Detroit Receiving Hospital, has, since its early days, assumed the responsibility for leadership in trauma care in the city of Detroit," according to the College. "Contributions to the literature of trauma by the Wayne State faculty '(who comprise the Detroit Receiving Department of Surgery staff), continue at a strong pace."

Applicants sought for geriatric fellowship

The Grand Rapids Family Practice Residency is seeking applicants for two first-year positions in the Grand Rapids Geriatric Fellowship. The two-year fellowship is designed to meet the essentials of the Accreditation Council for Graduate Medical Education.

The Grand Rapids Family Practice Residency is accepting physicians who are board-eligible or board certified by either the American Board of Family Practice or the American Board of Internal Medicine.

The fellowship graduates will qualify for the Certificate of Added Qualification examination, cosponsored by the American Boards of Internal Medicine and Family Practice.

For more information, or to make an interview appointment, contact: Rolland D. Mambourg, MD, director, Grand Rapids Geriatric Fellowship, Saint Mary's Health Services, 200 Jefferson, SE, Grand Rapids, MI 49503.

Patients needed for research projects

Kughn Clinical Research Center, University Hospital, University of Michigan, is seeking patients for the following studies:

Antigenic Challenge of an Isolated Airway Segment in Subjects with Asthma, Atopic-Nonasthmatics, and Normals.

The purpose of this study is to measure mediator release in the airways of subjects with mild asthma and to determine if there is a correlation between the mediator release and narrowing of the airways after the local instillation of an antigen. Subjects that participate in this study will be characterized as to their degree of airways responsiveness and their degree of allergic reaction to common antigens (grass, pollen, dog and cat dander, etc.) The subjects will then undergo bronchoscopy so that antigen still can be instilled directly in the lung. Saline solution then will be infused into the lung and withdrawn for cell analysis and measurements of mediator release. These studies may tell us what mediators are responsible for the airway constriction that occurs during an acute asthmatic attack.

For referral of patients to this study, contact: William Eschenbacher, MD, assistant professor of internal medicine, B1H272 University Hospital, Box 0026, (313) 936-5250.

Regulation of Vasoactive Peptide Hormone Release in Patients with Panic Disorder.

Despite extensive study of neuroendocrine mechanisms, the pathophysiological processes which produce panic attack symptoms remain unknown. A number of different lines of evidence suggest that vasoactive neuropeptides may be involved in the peripheral mediation of signs and symptoms of panic. Concurrent study of the responsiveness of several of these peptides to pentagastrin stimulation will be used to test this hypothesis. Panic patients will be compared to normal controls in blood levels of vasoactive intestinal peptide, substance P, neurokinin A, catecholamines and ACTH before and after pentagastrin infusion. We hypothesize that panic patients will show a greater release of peptides in response to pentagastrin than will normals.

Patients will have DSM-III-R defined Panic Disorder and no other current major psychiatric disorder. They also will be free of other major medical illness and will be non-smokers. They must be able to remain free of psychoactive medication for two weeks. They will receive detailed clinical and laboratory evaluations and be admitted overnight to the CRC. A two-hour pentagastrin stimulation test will be administered in the morning and the patients then will be discharged. Patients will receive free evaluations. Follow-up treatment will be available in the Anxiety Disorders Clinic on a flexible-fee schedule.

For further information, contact: James L. Abelson, MD, PhD, chief resident, University of Michigan Psychiatry, AAPH-5, Box 0705, (313) 764-5348.

A Comprehensive Evaluation of Hypothalamic-Pituitary-Adrenal Function in Patients with Panic Disorder before and after Treatment with Alprazolam.

The objective of this project is to evaluate hypothalamic-pituitary-adrenal (HPA) function in Panic Disorder and to assess whether alprazolam, therapeutic in the treatment of Panic Disorder, exerts its effects via influencing components of the HPA axis, particularly corticotropin-releasing hormone (CRH) secretion. To accomplish this task, we propose to thoroughly explore in panic patients pulsatile circadian

continued on next page

Continued from page 11

ACTH and cortisol secretion of 24 hours before and three hours after the acute administration of synthetic ovine CRH. The 24-hour sampling and CRH challenge will be done both in a drug-free, pretreatment state, and following 10 or more weeks of alprazolam administration. This study should allow assessment of the locus of disregulation of HPA function in patients with Panic Disorder and tell us how alprazolam interacts with all three components of the HPA axis in these patients.

The patients will be 18 to 40 year of age, will meet DSM-III-R criteria for Panic Disorder and must have had one panic attack per week for the three weeks prior to entering the study. They must be able to remain free of psychoactive medication for two weeks. They will receive detailed clinical and laboratory evaluations; be admitted overnight to the CRC for 24 hours of blood sampling and a CRH stimulation test; enter a 10-week, open-labeled treatment trial with alprazolam; and finally complete a second period of blood sampling in the CRC. They will receive free evaluation and treatment and $250 for participation in the study.

For further information, contact: James L. Abelson, MD, PhD, chief resident, University of Michigan Psychiatry, AAPH-5, Box 0705, (313) 764-5348.

Nursing Assessment of PMS

Women, ages 18 to 39, with severe premenstrual symptoms who have had a previous pregnancy, have no regular menstrual cycles and are taking no medications (progesterone or oral contraceptives), are needed for a study in the Clinical Research Center. Blood samples will be taken and a flexible work schedule is needed on four days. Compensation is $200.

For further information, contact: Lyn Conlon, project manager, Suite 2100, 400 North Ingalls Bldg., University of Michigan, Box 0482, (313) 936-3590.

Phase I/II Study of the Toxicity, Biologic Effect, and Efficacy of Radiolabeled Monoclonal Pan B-Cell Antibody MB-1 in the Treatment of B-Cell Lymplioma.

Patients with lymphoma who have been shown to be refractory tó other forms of treatment are eligible. After it is determined that patients have measurable disease which reacts with the MBI monoclonal antibody they may be eligible to receive 131 I-labeled MBI antibody in a low dose intravenously. Nuclear scanning studies are performed and then a higher dose of radioactive antibody is given. Patients then will be followed for various toxicity and biologic effects as well as response of their tumors to this form of treatment.

For further information, contact: Mark S. Kaminski, MD, assistant professor of internal medicine, Division of Hematology/Oncology, director, Leukemia/Lymphoma Program, University of Michigan Cancer Center, (313) 936-5290.

Intravenous Cyclophosphamide in Severe Systemic Lupus Erythematosus.

Severe Systemic Lupus involving the kidneys or central nervous system occasionally does not respond to treatment with corticosteroids such as prednisone. These patients may have severe prednisone side effects and yet not have significant improvement of their disease. Such patients may be candidates for treatment with monthly intravenous cyclophosphmide for a six month period. The research protocol provides this therapy, and requests that patients donate extra blood at the time for routine blood studies to be evaluated for white blood cell function and have several other studies related to the nervous system performed before and after treatment.

For further information, contact: W. Joseph McCune, MD, assistant professor of internal medicine, 3918 Taubman Center, Box 0358, (313) 936-5565.

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the 28th Annual Michigan Conference on Maternal and Perinatal Health

The perinatal health care professional attending this conference will have an opportunity to interact with a multidisciplinary faculty addressing present and future concerns in maternal and child health. At the conclusion, the participant should be able to:

Obstetric Concerns

- learn the cost of drug abuse crime on perinatal care
- become familiar with new neonatal technologies
- recognize new perinatal nursing practices
- explore moral issues of reproductive technology
- learn our role in the care of the battered female
- learn new techniques of recognizing and treating premature labor
- define the myths and facts of the AIDS hysteria
- help the pregnant patient to recognize her role to her developing infant
- learn the role of PUBS in obstetrics
- to become aware of fetal monitoring problems
- learn how ultrasound helps to diagnose CNS and cardiovascular problems
- explore legal issues of obstetrics
- find ways to lower the caesarean section rate
- learn of a new delivery room management plan
- recognize the role of multidisciplinary problem-solving in approaching difficult perinatal dilemmas

Pediatric Concerns

- understand the present "state of the art" in neonatal medicine
- recognize philosophical and ethical issues engendered by high technology care
- be familiar with the neurologic outcomes of newborns treated with extracorporeal membrane oxygenation
- evaluate the usefulness and limitations of the APGAR scoring system
- be aware of present recommendations for the management of apnea syndromes
- understand new approaches to treat severe retinopathy of prematurity
- identify methods for reducing stress in neonatal intensive care units
- comprehend potential indications for the use of intravenous immunoglobulins in the treatment of neonatal infections
- become familiar with the principles and uses of magnetic resonance imaging in the newborn
- identify new approaches to vascular access in the neonatal patient
- understand difficult management decisions in the delivery room
- recognize the role of multidisciplinary problem-solving in approaching difficult perinatal dilemmas.

The Maternal and Perinatal Health Conference Planning Committee

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The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 12 hours in Category I toward the requirements for Michigan licensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Wednesday Morning, March 22

7:30 a.m.
Registration, Continental Breakfast

8:15 a.m.
General Session: "Impact of Newer Technology"

Welcome: Frederick W. Bryant, MD, President, Michigan State Medical Society

Moderator: James W. Gell, MD, Chairman, Michigan Section, American College of Obstetricians and Gynecologists

8:30
"Substance Abuse: Crime, Cost and Maternal/Perinatal Health"
Charles C. Vincent, MD, Chief, Department of Gynecology, Hutzel Hospital/Detroit Receiving; Chairman, Michigan Board of Medicine

9:00
"State of the Art in Neonatology"
J. Devn Cornish, MD, Assistant Professor, Department of Pediatrics, University of California San Diego School of Medicine; Staff Neonatologist, Children's Hospital and Health Center, San Diego; Director, Regional ECMO Program

9:45
Break

10:15
"Technology and Perinatal Nursing Practice"
Carol Ann Consolvo, RN, MS, Assistant Professor, Department of Pediatrics, University of Texas Medical School at Houston

11:00
"Moral Issues Presented by New Reproductive Technologies"
Carl Cohen, PhD, Professor, Department of Philosophy; Director, Human Values in Medicine, University of Michigan Medical School

11:45
Question and Answer Session (all speakers)

12 NOON
Adjourn to luncheon poster presentation

Wednesday Afternoon, March 22

Concurrent Sessions in A) Obstetrics and B) Pediatrics

A

Obstetrics "Today's Dilemmas"
Moderator: John Addy, MD, Conference Co-Chairman, Lansing

B

Pediatrics "High Tech Neonatology"
Moderator: Steven Donn, MD, Conference Co-Chairman, Associate Professor, Department of Pediatrics, Section of Newborn Services, University of Michigan Medical Center

1:30 p.m.	"The Battered Woman" Ronald A. Chez, MD, Professor and Vice Chairman, Department of Obstetrics and Gynecology, New Jersey Medical School	"Magnetic Resonance Imaging in Neonatal/Perinatal Medicine" Marcus C. Hermansen, MD, Director, Department of Neonatology, Allegheny General Hospital and the Medical College of Pennsylvania, Pittsburgh
2:00 p.m.	"Pre-term Labor" Clark E. Nugent, MD, Instructor, Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor	"Follow-up Studies on Infants Treated with Extracorporeal Membrane Oxygenation" Robert E. Schumacher, MD, Assistant Professor, Department of Pediatrics, Section of Newborn Services, University of Michigan
2:30 p.m.	Break	Break
3:00 p.m.	"AIDS Hysteria" Joyce Farrer, RN, Henry Ford Hospital, Detroit	"Vascular Access in the Neonate" Mary Kay Chathas, RN, MSN, PCVC Research Coordinator, and Tracy Lin, RN, MS, PCVC Clinical Coordinator, Michael Reese Hospital & Medical Center, Chicago
3:30 p.m.	"Maternal Responsibility for Perinatal Well-Being" Ronald A. Chez, MD, Professor and Vice Chairman, Department of Obstetrics and Gynecology, New Jersey Medical School	"New Approaches to Congenital Heart Disease" William Pinsky, MD, Children's Hospital, Detroit
4:00 p.m.	Question and Answer Session All Speakers	Question and Answer Session All Speakers
4:30 p.m.	Adjournment	Adjournment

Thursday Morning, March 23

7:30 a.m.
Registration, Continental Breakfast

Concurrent Sessions in A) Obstetrics and B) Pediatrics

A	**B**
Obstetrics "Diagnostic Techniques" Moderator: Federico Mariona, MD Professor, Department of Obstetrics, Wayne State University; Director, Maternal and Fetal Medicine, Oakwood Hospital	**Pediatrics** "Looking Through the Retrospectroscope" Moderator: Ronald Poland, MD, Children's Hospital of Michigan, Detroit

8:30 a.m.	"Percutaneous Umbilical Blood Sampling (PUBS)" Alan J. Sacks, MD, Division of Obstetrics and Gynecology Imaging Wayne State University/Hutzel Hospital, Detroit	"Are APGAR Scores Still Worthwhile?" Marcus C. Hermansen, MD, Director, Department of Neonatology, Allegheny General Hospital, and The Medical College of Pennsylvania, Pittsburgh
9:00 a.m.	"Pitfalls of Fetal Monitoring" Bonnie Flood-Chez, RN, New Jersey	"Management of Apnea in Michigan" David S. Sciamanna, DO, Neonatologist, Sparrow Hospital; Associate Professor, Department of Pediatrics, Michigan State University College of Osteopathic and Human Medicine, Lansing
9:30 a.m.	Break	Break
10:00 a.m.	"Fetal CNS Abnormalities" Frank A. Chervenak, MD, Associate Professor, Department of Obstetrics and Gynecology; Director, Department of Obstetric Ultrasound and Ethics, New York Hospital-Cornell Medical Center	"Comprehensive Management of Retinopathy of Prematurity" Michael Trese, MD, Clinical Associate Professor, Kresge Eye Institute, Wayne State University; William Beaumont Hospital
10:30 a.m.	"The Fetal Cardiovascular System" Christine Comstock, MD, Director, Division of Fetal Imaging, Department of Obstetrics and Gynecology, William Beaumont Hospital, Royal Oak	"Infant Stimulation versus Developmental Interventions in the NICU" Susan Blackburn, RN, PhD, Associate Professor, Department of Parent and Child Nursing, University of Washington, Seattle

11:00 a.m.
Question and Answer with All Speakers

11:30 a.m.

Adjourn to Luncheon Meetings: (all concurrent sessions)

"Legal Issues" Bonnie Flood-Chez, RN, New Jersey

"Stress Reduction in Neonatal Intensive Care and Step-Down Units" Tracy Lin, MS, RN, and Mary Kay Chathas, MSN, RN, Chicago

"Peculiar Eruptions in Pregnancy" Edward Krull, MD, Henry Ford Hospital

"Understanding Neonatal Behavior" Susan Blackburn, RN, PhD, Associate Professor, Department of Parent and Child Nursing, University of Washington, Seattle

"Intravenous Immunoglobulin for Neonatal Infection: Yes or No?" Roger C. Faix, MD, Associate Professor, Department of Pediatrics; Staff Neonatologist, University of Michigan Medical Center

"Caesarean Section Revisited" George Nolan, MD, Henry Ford Hospital

"Delivery Room Management" Ronald Poland, MD, Children's Hospital of Michigan, Detroit

Thursday Afternoon, March 23

1:30 p.m.
General Session, "Full Speed Ahead: A Multidisciplinary Approach to Perinatal Decision-Making"

This portion of the program will be presented in format of a panel presented with a case (congenital diaphragmatic hernia). Doctor Thomas Schwenk, MD, family physician, will present the case and act as patient advocate.

Introduction: Robert Lorenz, MD, Director, Maternal and Fetal Medicine, William Beaumont Hospital, Royal Oak

Moderator: John V. Hartline, MD, President, National Perinatal Association; Neonatologist, Bronson Methodist Hospital and Borgess Medical Center, Kalamazoo

(Doctor Hartline will introduce panel and later present the variables, including chromosomal anomaly, economic factors, fetal surgery)

1:45 p.m.
Case Presentation Participants:

Frank Chervenak, MD, Associate Professor, Director of Obstetric Ultrasound and Ethics, Department of Obstetrics and Gynecology, New York Hospital-Cornell Medical Center, New York

Mason Barr, MD, Department of Pediatrics, University of Michigan Medical School

Leannė Roman, RN, PhD, Clinical Nurse Research Associate, Butterworth Hospital, Grand Rapids and Institute for Family and Child Study, Michigan State University College of Human Ecology

J. Devn Cornish, MD, Assistant Professor, Department of Pediatrics; Staff Neonatologist, Children's Hospital and Health Center, San Diego

Each will give 15 minute presentations on the medical, ethical and social aspects within their specialty.

2:45 p.m.
Recess to Prepare Questions

3:00 p.m.
Reconvene for "Stump the Panel" (Presentation of problems in the case)

3:45 p.m.
Conference Adjourns

28th Annual Michigan Conference on Maternal and Perinatal Health

March 22 & 23, 1989 Hyatt Regency Dearborn

Wednesday Morning, March 22-General Session: "Impact of Newer Technology"

7:30 Registration, Continental Breakfast
8:15 Welcome
8:30 "Substance Abuse: Crime, Cost and Maternal/Perinatal Health"
9:00 "State of the Art in Neonatology"
9:45 Break
10:15 "Technology and Perinatal Nursing Practice"
11:00 "Moral Issues Presented by New Reproductive Technologies"
11:45 Question and Answer Session with All Speakers
Noon Adjourn to Luncheon Poster Presentation

Wednesday Afternoon, March 22-Concurrent Sessions in A) Obstetrics and B) Pediatrics

	A Obstetrics: "Today's Dilemmas"	B Pediatrics: "High Tech Neonatology"
1:30	"The Battered Woman"	"Magnetic Resonance Imaging in Neonatal/Perinatal Medicine"
2:00	"Pre-term Labor"	"Follow-up Studies on Infants Treated with Extracorporeal Membrane Oxygenation"
2:30	Break	Break
3:00	"AIDS Hysteria"	"Vascular Access in the Neonate"
3:30	"Maternal Responsibility for Perinatal Well-being"	"New Approaches to Congenital Heart Disease"
4:00	Question and Answer Session	Question and Answer Session
4:30	Adjournment	Adjournment

Thursday Morning, March 23-Concurrent Sessions in A) Obstetrics and B) Pediatrics

	A Obstetrics: "Diagnostic Techniques"	B Pediatrics: "Looking Through the Retrospectroscope"
7:30	Registration, Continental Breakfast	Registration, Continental Breakfast
8:30	"Percutaneous Umbilical Blood Sampling"	"Are APGAR Scores Still Worthwhile?"
9:00	"Pitfalls of Fetal Monitoring"	"Management of Apnea: An Update"
9:30	Break	Break
10:00	"Fetal CNS Abnormalities"	"Comprehensive Management of Retinopathy of Prematurity"
10:30	"The Fetal Cardiovascular System"	"Infant Stimulation vs. Developmental Interventions"
11:00	Question and Answer Session	Question and Answer Session
11:30	Adjourn to Luncheon Meetings	Adjourn to Luncheon Meetings

Thursday Afternoon, March 23-General Session "Full Speed Ahead: A Multidisciplinary Approach to Perinatal Decision-Making"

1:30 Introduction
1:45 Case Presentation
2:45 Recess for Panel Preparation
3:00 Reconvene for "Stump the Panel" (Presentation of problems in the case)
3:45 Conference Adjourns

Retain this portion

- -

Advance Registration For Michigan Conference on Maternal and Perinatal Health

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City ______________ State _____ Zip ________
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MSMS Member: Yes _____ No _____ Specialty __________
Nurse _____ Resident _____ Other __________

Wednesday, March 22, 1989

☐ Full-Day Session ($50 includes Poster/Luncheon) $ ______

☐ Poster/Luncheon (please check if you will attend)

☐ Choose one topic for afternoon concurrent session:
- ___ A: Obstetrics
- ___ B: Pediatrics

Wednesday Total = $ ______

Tuition Schedule

Physicians, Nurses and Others:
$50 Wednesday (includes lunch)
$40 Thursday (luncheon meeting optional)
Residents & Students: No charge for Full-day Sessions (lunch is $10 each day)
Luncheon: $10 for All Registrants

Checks payable to: Michigan State Medical Society

Thursday, March 23, 1989

☐ Choose one topic for morning concurrent sessions: $ ______
- ___ A: Obstetrics
- ___ B: Pediatrics

☐ Luncheon Meeting (indicate 1st & 2nd choices): $ ______
- ___ Legal Issues
- ___ Stress Reduction in Neonatal Care
- ___ Peculiar Eruptions in Pregnancy
- ___ Reading Neonatal Behavior Cues
- ___ Intravenous Immunoglobulin
- ___ Caesarean Section Revisited
- ___ Delivery Room Management

Thursday Total = $ ______

Please complete and mail with your check to MSMS, P. O. Box 950, East Lansing, MI 48826-0950, (517/337-1351). **Grand Total = $** ______
Confirmation of your registration will be sent to you with a reservation card.

Send this portion

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Hutzel Hospital has been providing primary research and clinical leadership in the reproductive sciences for more than a century. Today, working with the Wayne State University School of Medicine, Hutzel offers one of the most advanced, comprehensive and effective fertility programs in America. Some highlights:

- Couples are treated together at Hutzel. They are not, as a matter of course, referred out to individual, gender-specific specialists.
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  - One of Michigan's first ultrasound egg retrieval programs.
  - Michigan's first, and to date only, cryopreservation program (very important in reducing multiple birth risks).
  - Board-Certified reproductive endocrinologists at Hutzel have trained many of the specialists working in this area.
- In spite of its unique quality level, charges at Hutzel are generally slightly less than at local hospital clinics.
- The Hutzel Fertility Center's modern facilities are located on the Hutzel Hospital Campus at The Detroit Medical Center, and recently have been expanded by more than 40 percent to accommodate growing demand.

Couples undertaking any fertility program usually make substantial emotional and economic investments. By recommending the most comprehensive program, you offer your patients the greatest chance of success.

For more information about any of Hutzel's fertility programs, please call 745-0499 or 577-1066.

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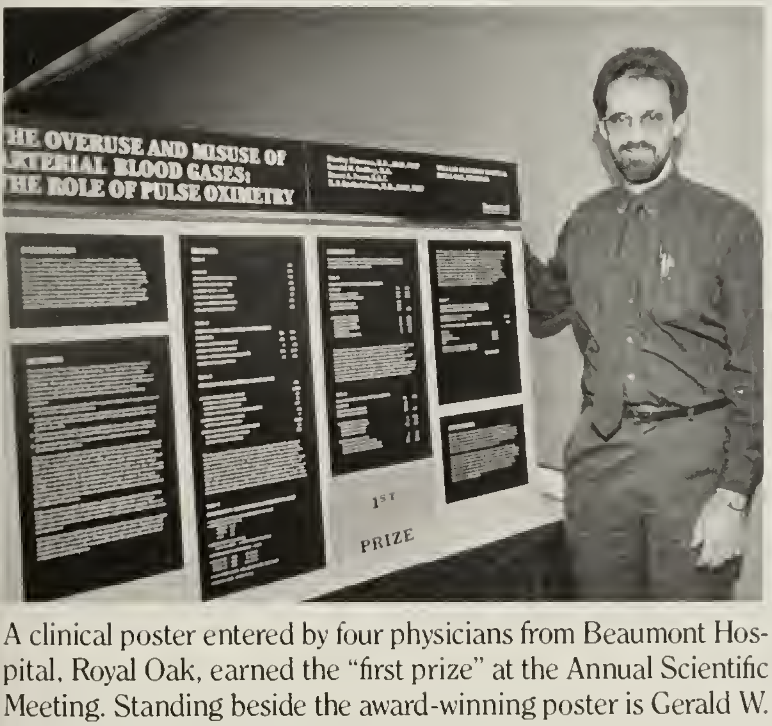
MSMS
Annual Scientific Meeting Highlights

The three-day MSMS Annual Scientific Meeting takes much planning and coordination. The 1988 event at the Hyatt Regency Dearborn was chaired by Joan C. Stryker, MD, and her Annual Scientific Meeting Planning Committee. Doctor Stryker (above) takes a moment to welcome MSMS staff to the meeting and to thank them in advance for their assistance.

REGISTRATION
CASHIER
ON-SITE REGISTRATION

At the MSMS registration desk, MSMS staff members provided physicians with course and luncheon tickets, and answered questions. Approximately 1,000 physicians attended the 1988 event.


HE OVERUSE AND MISUSE OF
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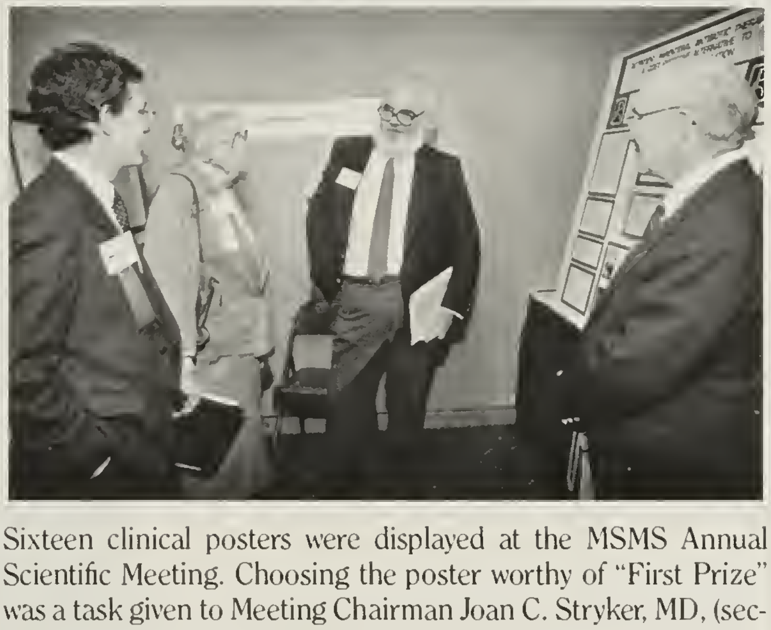
HE ROLE OF PULSE OXIMETRY
1ST
PRIZE

A clinical poster entered by four physicians from Beaumont Hospital, Royal Oak, earned the "first prize" at the Annual Scientific Meeting. Standing beside the award-winning poster is Gerald W. Godfrey, MD, one of the four physicians who created the poster.



Sixteen clinical posters were displayed at the MSMS Annual Scientific Meeting. Choosing the poster worthy of "First Prize" was a task given to Meeting Chairman Joan C. Stryker, MD, (second from left), Michigan State University College of Human Medicine Dean W. Donald Weston, MD, (center), and MSMS President Fred W. Bryant, MD, (far right). Charles N. Ellis, MD, (far left), was on hand to discuss his poster, "Topical Tretinoin Improves Photoaging."

James Curran, MD, AIDS program director, Centers for Disease Control, Atlanta, provided a one-hour national perspective on AIDS at the first-ever plenary session at the Annual Scientific Meeting. Doctor Curran told physicians: "One of the things we need to do to get AIDS under control is to get more physicians involved." About 150 physicians gathered to hear Doctor Curran's 7 a.m. presentation.

Evelyn J. Fisher, MD, attending physician, Infectious Diseases, Henry Ford Hospital, Detroit, (at podium), was one of four physicians who spoke at the "AIDS Update" session at the Annual Scientific Meeting.

U.S. ARMY MEDICAL DEPARTMENT

Approximately 70 exhibitors featured their products and informational brochures at the Annual Scientific Meeting. Exhibitors were on hand throughout the three-day event to speak with attendees and to answer questions.

WLQV am 1500

Bud Bihl, (right), host for radio station WLQV AM 1500 in Trenton, questioned MSMS President Fred W. Bryant, MD, on some of the more pressing issues surrounding AIDS. The interview, which took place inside the exhibit hall, was aired live.

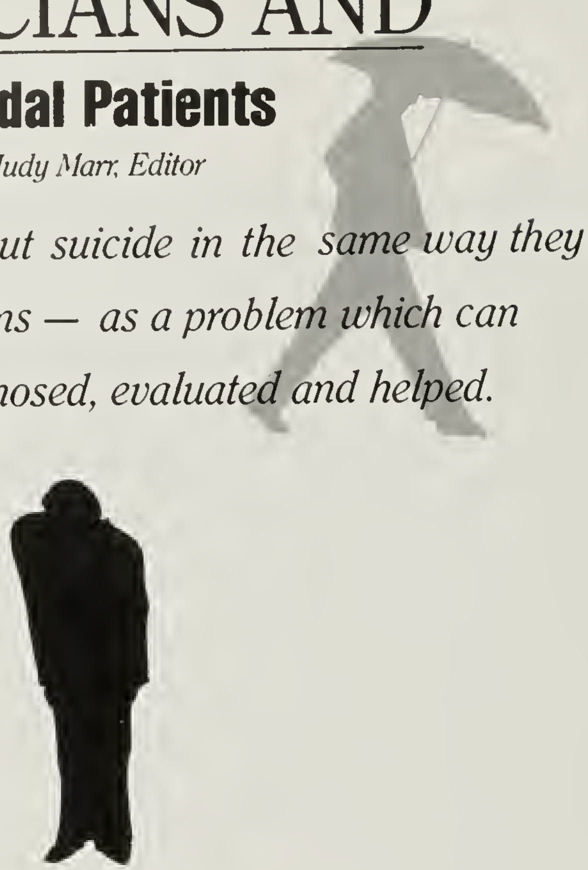
Robert K. Orr, Jr., DO, Lansing, showed physicians how to treat adult airway obstruction as part of his ever-popular course on "Basic Cardiac Life Support."

PHYSICIANS AND

Suicidal Patients

By Judy Marr, Editor

Physicians should think about suicide in the same way they think about other conditions — as a problem which can be suspected, diagnosed, evaluated and helped.



Death from suicide is like any other death, and should be treated as such.

That was the message of MSMS Annual Scientific Meeting Speaker Harvey H. Falit, MD, Psychiatry Department, University of Michigan Medical School. Doctor Falit served as course director of "The Suicidal Patient and The Primary Care Physician," presented November 10 at the Hyatt Regency Dearborn.

A significant number of suicides are preventable, said Doctor Falit. They stem from a diagnosable psychiatric disorder which leads to suicide.

"I would discourage the following line of thinking — that 'the patient's psychiatric problems are of no concern to me,'" he said. "Unfortunately, however, that is not an uncommon way of thinking."

The Annual Scientific Meeting speaker told the physicians that "a significant aspect of dealing with the suicidal patient has to do with the force of your personality. It has to do with your ability to make a relationship, to listen, and to take the necessary actions."

Doctor Falit warned against "dangerous" reactions on the part of physicians toward suicidal patients:

1) Withdrawal, apathy — the feeling that nothing can be done.

2) Self-criticism of one's own feelings.

3.) Anger, hostility. "You see this strikingly in the emergency room — almost contempt," he observed.

4.) Intense desire to save the patient — the belief that the physician could be the only one to save the patient.

All of us have reactions to psychiatric patients, Doctor Falit continued. They stir up a great variety of feelings.

"It's not a question of whether we will have those feelings. It's that when they occur we should know what we are going through and not allow them to play a role."

Instead, he offered some positive behaviors for physicians in dealing with suicidal patients.

Most importantly, he encouraged physicians to ask about a patients' mental state.

"A common concern is whether or not to ask if a patient is suicidal, for fear that asking can make him suicidal. There is no evidence to that effect," said Doctor Halit.

He suggested asking, "Have you been depressed lately? How bad have things been for you?" He suggested going as far as asking whether a patient has thoughts of killing himself, or whether there is a family history of suicide.

"If you don't ask, in some patients this communicates the idea you don't care, or are afraid to ask.

"Some patients won't tell the truth, and others are determined to commit suicide," he acknowledged. "But I think it is incorrect to conclude it is not worth asking. It may simply make the patient aware they can talk about it to someone else."

He cautioned his colleagues to consider how they prescribe medications to those at risk for suicide.

"Your precautions may be life-saving. Large doses may communicate to the patient you don't care, are not aware, or even want him to commit suicide."

Doctor Falit debunked "suicide myths":

1) An attempt is just a gesture. "All suicide attempts should be treated as serious, and require careful evaluation."

2) If a person talks about committing suicide, he won't do it. "Fifty to 80 percent of those who complete suicide have communicated their attempt to someone important to them. Often they are not subtle, but are direct."

"A significant number will tell you about it, if you are open to them," he said. "A significant number will be trying to communicate it, and you may be the one they talk to."

One study has shown the average physician will encounter six potential suicides in a year, he reported. Other studies show a large number of suicide victims have been to see their physicians prior to the event.

"If your index of suspicion is raised by a concurrence of statistics, or the patient's recent loss, or obvious depression, or by communication, said Doctor Falit, it's crucial that the physician ask about the patient.

"Remember, you are often diagnosing something very treatable," he concluded.

Continued on page 25

Editor's note: This is the first in a series of features highlighting courses held at the 1988 MSMS Annual Scientific Meeting.

Survivors Need Special Care

The survivors — those left behind by the suicide — are perhaps the best population among which to practice suicide prevention.

So suggested Albert C. Cain, PhD, chairman, University of Michigan Department of Psychology, at the Hyatt Regency November 10. Doctor Cain was a speaker in the MSMS Annual Scientific Meeting course, "The Suicidal Patient and the Primary Care Physician."

With 25,000 to 50,000 suicides occurring each year in the United States, said Doctor Cain, there are another 200,000 closely-related persons newly-affected by the suicides.

"This has led folks to recognize that we have a major public health problem in those left behind," he said. "They are increasingly referred to as the high-risk, vulnerable population."

Indeed, he continued, if there is a suicide in the family background, there is a strikingly higher likelihood of one's taking his own life. The ratio is described as everywhere from 3:1 to 80:1 times more likely that the person will attempt or complete suicide, he said.

Doctor Cain described the impact of societal attitudes about suicide upon affected families.

"Suicide is still highly stigmatized in this country," he said, "with our basic behaviors in the event of suicide being avoidance, disgrace and shame."

He pointed out there are no institutions to relieve the burdens of suicide. In addition, he said, "stigma multiplies the problems of mourning and coping on the family's part."

A Look at the Statistics

Suicide is the ninth leading cause of death. It is the third leading cause of death among adolescents, ranking behind accidents and cancer.

These were among the statistics shared by speakers in the course on "The Suicidal Patient and the Practicing Physician," presented November 10 during the MSMS Annual Scientific Meeting. The course took place at the Hyatt Regency Dearborn.

Here are more statistics:

1) Suicide is three times more common among men than among women, though women make more attempts.

2) Men use more violent means to commit suicide.

3) Fifteen percent of all successful suicides are committed by persons over the age of 65, though they comprise just 11 percent of the population.

4) Fifty to 80 percent of those who commit suicide have communicated their attempt to someone important to them.

5) Twenty-seven percent of those who try and fail kill themselves within a year of their attempt, and an additional 10 percent over their lifetimes.

6) The incidence of suicide is higher in those who live alone.

7) Physicians have a higher suicide rate than does the general population.

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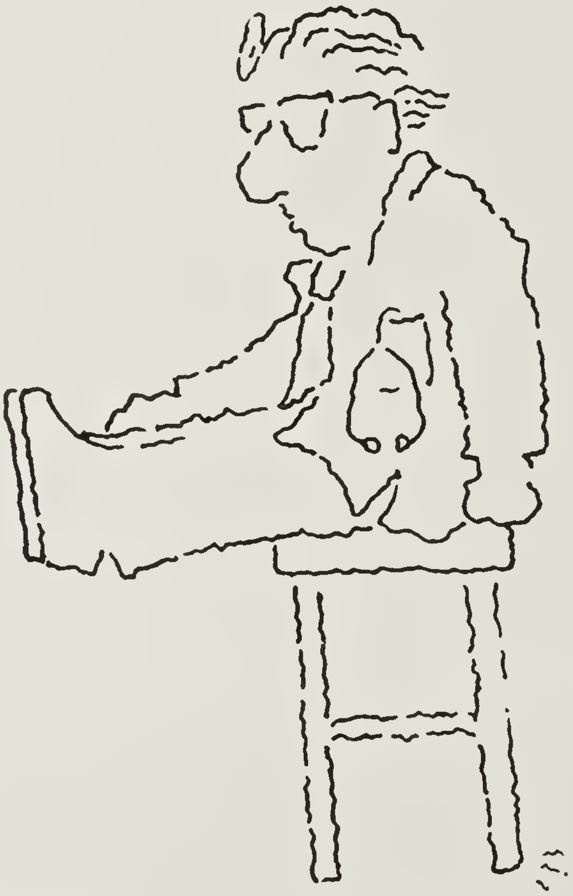

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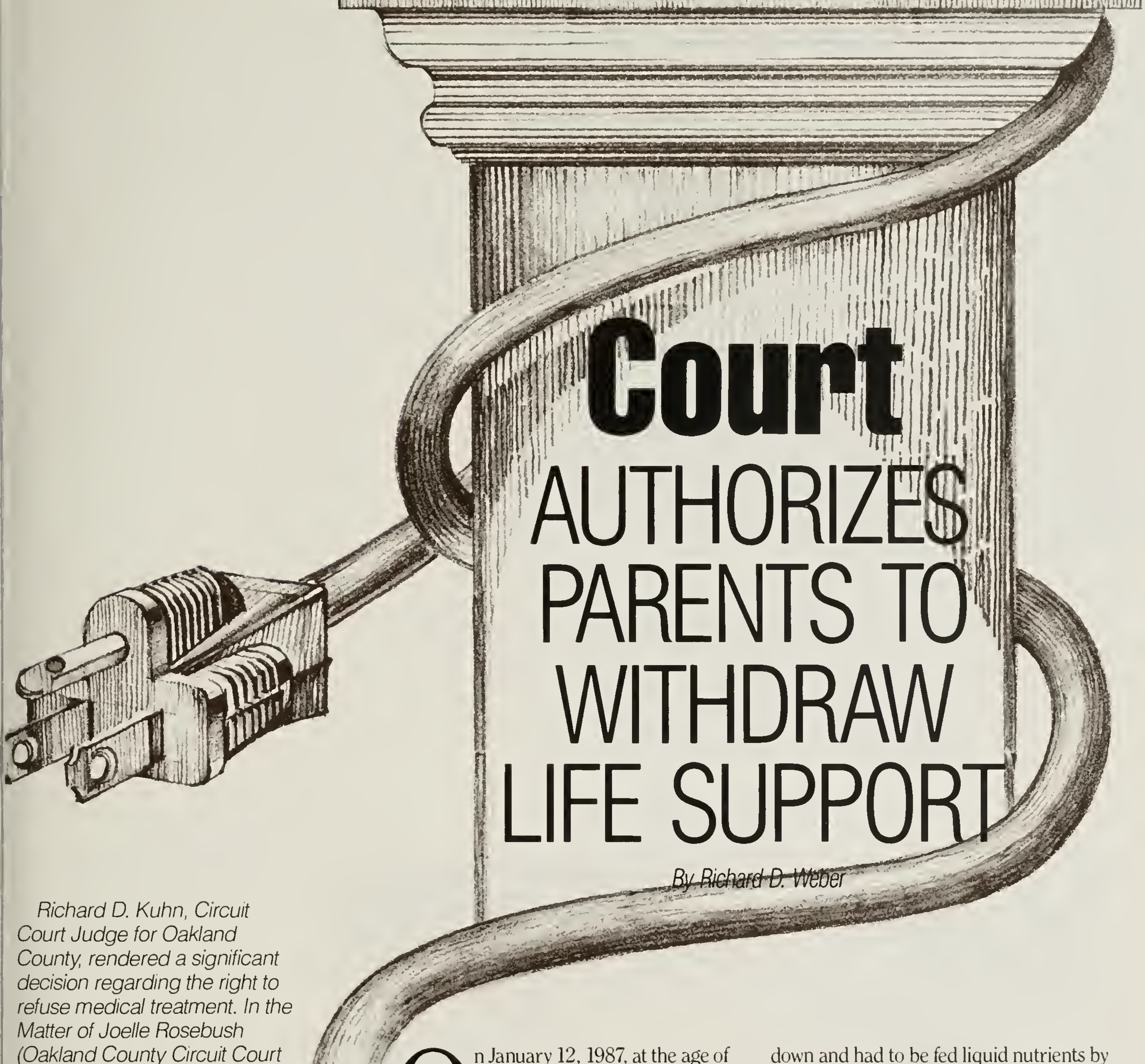

Court AUTHORIZES PARENTS TO WITHDRAW LIFE SUPPORT

By Richard D. Weber

Richard D. Kuhn, Circuit Court Judge for Oakland County, rendered a significant decision regarding the right to refuse medical treatment. In the Matter of Joelle Rosebush (Oakland County Circuit Court Case No. 88 349180 AZ), Judge Kuhn authorized the parents to withdraw life support systems from their child, notwithstanding the fact that "brain death" under the Michigan Determination of Death Act had not occurred. Following withdrawal of life support systems and the death of the child, the Oakland County prosecutor appealed the case. The Michigan appellate courts will decide the issue and establish precedent. Because of the importance of this trial court opinion to Michigan physicians, MSMS legal counsel, Richard D. Weber, has prepared a summary of the lengthy opinion.

On January 12, 1987, at the age of eleven, Joelle Rosebush sustained serious multiple injuries in a traffic accident. At the time of the accident, she experienced a cardiac arrest which resulted in brain injury. Joelle was admitted to Lapeer County General Hospital where she was placed on a ventilator, and later transferred to William Beaumont Hospital. In June 1987, Joelle was taken to the Neurorehabilitation Center within the Georgian Bloomfield Nursing Home, in Oakland County, where she resided at the time this action was instituted.

As a result of her accident, Joelle's spinal cord was severed at the C-1 level, which constitutes the highest level of the spine just below the skull bone. This injury rendered Joelle a quadraplegic. She was completely paralyzed from the neck down and had to be fed liquid nutrients by a tube inserted into her stomach since she could not eat through her mouth. She required a respirator for breathing.

The physicians who testified during the proceeding diagnosed Joelle's neurologic injury as a persistent vegetative state that offered no chance for recovery. She did not respond to stimulation in even a remotely cognitive manner. However, Joelle was not "brain dead" as defined by Michigan law because her brain stem, which controls respiration, was not irreparably injured.

Soon after Joelle's accident, her parents were advised by physicians that there was no possibility that Joelle's condition would ever improve. Despite this news, they sought to find the best rehabilitive therapy available for their daughter, and had her transferred to the Neurorehabilitation

continued on next page

Center in June of 1987. The Court found on the basis of expert testimony that Joelle's condition had not appreciably improved during her confinement at the rehabilitation facility.

Joelle's case was then presented to the Bioethics Committee of Children's Hospital. The committee is designed to insure a full and fair review of medical-ethical problems, and was highly praised by the Court. The committee recommended that Joelle be transferred to Children's Hospital. It was this potential transfer which lead to the institution of this action by the Oakland County Prosecutor.

A temporary restraining order was obtained on May 10, 1988, prohibiting the transfer of Joelle from the nursing home and enjoining removal of her artificial means of life support. Two or three individuals, including nurses who had cared for Joelle, believed the parents' decision to be wrong and unlawful. These persons made known their position to the prosecutor so that action could be taken to halt implementation of the parents' decision.

The parents then filed a petition requesting that the Court issue an order entitling them to determine the type and scope of medical care to be provided to Joelle.

Judge Richard Kuhn, after appointing a guardian ad litem to represent Joelle's interest, holding a seven-day hearing, and making a personal visit to the bedside of Joelle, issued an order on July 29, 1988, authorizing Frances and Jacklyn Rosebush to make any and all decisions regarding the medical treatment received by their daughter, including the authority to order the removal of life-support machinery.

In the Court's well-reasoned opinion, it was noted that issues of this nature had never been tried in a contested manner. All steps taken by Joelle's parents to insure her proper care and treatment were carefully examined. This included their meeting with the Bioethics Committee, their church, and countless physicians. There was some evidence presented by those who cared for Joelle that her condition had been improving. These individuals contended that she had spoken on occasion, had focused on objects for short periods of time, and could track the movement of persons in the room. The Court held that this evidence failed to meet a clear and convincing burden of proof standard. This reasoning was based upon medical testimony which revealed that these observations did not constitute purposeful behavior, but were nothing more than primitive reflex actions.

The Court found that it was the State's parens patriae power which supported the authority of the Court to allow decisions to be made for the incompetent. Although the prosecution argued that the Court should not permit the discontinuance of Joelle's life support systems at the request of third parties where she was in a persistent vegetative state which was not terminal, the Court responded by recognizing a constitutional right to refuse medical treatment and an unwritten constitutional right of privacy. The Court emphasized that the freedom to exercise a constitutional right does not depend on the individual's competency.

In order to guide surrogate decision making, the Court considered two standards: substituted judgment and best interests. The Court utilized the best interests standard, in which the surrogate decision-maker assesses what medical treatment would be in the patient's best interest. Un-

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Continued from page 28

der this standard, the Court was firmly convinced that the decision of Joelle's parents was the correct one and should be adopted by the Court.

The next step taken by the Court was to consider the four state interests which may militate against allowing the exercise of a patient's rights. These four interests are:

1. The preservation of life.
2. The protection of the interests of innocent third parties.
3. The prevention of suicide.
4. Maintaining the ethical integrity of the medical profession.

In considering the preservation of life, the Court noted that the issue in this case was not the preservation of life, but whether the state's interest in prolonging death should override Joelle's constitutional right to privacy and self-determination. The Court recognized that where the treatment required would be highly evasive and intrusive, and terminally-ill individual's right to refuse treatment must prevail.

The protection of third parties was not at issue in this case because Joelle was a minor, having no children. The prevention of suicide was also not at issue, since the decision to withdraw Joelle's life support would not be a decision that allowed suicide, but rather a decision that allowed self-determination and the natural, inevitable, end result of Joelle's injuries. Finally, the state's interest in safeguarding the ethical integrity of the medical profession was not logically an issue since the proposed course of treatment was not in conflict with accepted medical ethics.

Final judgement

After finding that none of the interests of the state took precedent over Joelle's constitutional right to privacy, the Court addressed the prosecutor's argument that removal of Joelle's life support conflicted with the Determination of Death Act, MCL 333.1021-1024. However, the Court pointed out that a proper interpretation of the Act revealed that it was only intended to provide a standard for determining death and had nothing to do with medical care decisions per se. Also rejected was the prosecutor's request that the Court order a new diagnostic test for Joelle and delay a decision for six months, to allow Joelle a full two-year recovery period.

Evidence at trial clearly and convincingly demonstrated the validity of Joelle's diagnosis and prognosis, and no test was warranted. Finally, the Court ordered that Joelle's parents, or other medical personnel, would suffer no potential criminal or civil liability in connection with any decision regarding Joelle's treatment, including the removal of life-support machinery. ■

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CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

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Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient

Laboratory Tests: Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS**.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

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Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS**, and **OVERDOSAGE). ** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1 Elimination of foods and medications containing potassium and of potassium-sparing diuretics.

2 Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.

3. Correction of acidosis, if present, with intravenous sodium bicarbonate.

4 Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Barry A. Breakey, MD
Action, Date Taken: Fined $500 and 100 hours of community service, November 18, 1988.
Reason: Lack of good moral character.

Name: Michael J. Gallagher, MD
Action, Date Taken: Suspension-indefinite, October 19, 1988.
Reason: Mental/physical impairment.

Name: Warren R. Garr, MD
Action, Date Taken: Reprimand; Probation-one year, December 16, 1988
Reason: Drug related.

Name: Lakshmi K. Kenue, MD
Action, Date Taken: Suspension-six months and one day, November 18, 1988.
Reason: Drug related.

Name: Ekhiel F. Khait, MD
Action, Date Taken: Voluntary surrender, December 16, 1988.
Reason: Unethical business practice.

Name: Mohammed A. Mannan, MD
Action, Date Taken: Reprimand; Probation, two years; Fine $500.
Reason: Unprofessional conduct.

Name: Henry H. Modrak, MD
Action, Date Taken: Probation-two years; Reprimand-Fine $500, Earn 100 Category I hours in addition to the 150 CME mandated for license renewal, October 13, 1988.
Reason: Failed to demonstrate compliance with CME required for relicensure.

Name: Joseph H. Naud, MD
Action, Date Taken: Reprimand, December 16, 1988.
Reason: Negligence.

Name: Phillip B. Shepard, MD
Action, Date Taken: Revocation, November 18, 1988.
Reason: Criminal conviction/Sexual misconduct.

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1989 PSG seminar schedule

MSMS members are invited to attend any of the following seminars planned by the MSMS subsidiary, Physician Service Group Inc., for 1989. Registration information about the seminars will appear in future issues of Michigan Medicine and Medigram. Other workshops and seminars may be developed and offered by PSG throughout 1989. Each workshop and seminar will be preceded by a special brochure announcing the program and workshop dates. For details, contact Amy Fistler at MSMS (517) 337-1351.

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CPT Coding (1/2 day)
Competitive Edge (1/2 day)
February 23
Grand Rapids

Third Party Reimbursement and Coding
(Conomikes Associates, Inc.)

March 15
Livonia

March 16
Kalamazoo

October 11
Detroit Area

October 12
Grand Rapids

Health Law Update (1/2 day)
(Kerr, Russell & Weber)

April 5
Detroit Area

October 4
Grand Rapids

Medicare Update (1/2 day)
April 12
Marquette

April 13
Traverse City

April 19
Grand Rapids

April 20
Southfield

Computerization of Medical Financial Billing & Collecting/ Practice

April 26
Kalamazoo

April 27
Flint

Defensive Planning (1/2 day)

May 3
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(sucralfate) Tablets

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

Reference:
1 Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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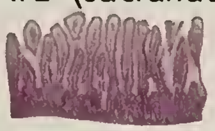
Aspirin and other nonsteroidal anti-inflammatory drugs weaken mucosal defenses, which may lead NSAID users to become prone to duodenal ulcers.[1] For those NSAID users who do develop duodenal ulcers, CARAFATE® (sucralfate/Marion) is ideal first-line therapy. Carafate rebuilds mucosal  defenses through a unique, nonsystemic mode of action. Carafate enhances the body's natural healing ability while it protects damaged mucosa from further injury. So the next time you see an arthritis patient with a duodenal ulcer, prescribe nonsystemic Carafate: therapy for the ulcer-prone patient.

Unique, nonsystemic

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Please see brief summary of prescribing information, and reference on adjacent page.

0160N8

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Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN SENSITIVE PATIENTS PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS

Administer cautiously to allergic patients

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old Ceclor penetrates mother's milk Exercise caution in prescribing for these patients

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include
- Gastrointestinal (mostly diarrhea). 2 5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever) 1 5%, usually subside within a few days after cessation of therapy Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other: eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061088L]

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MSMS/MSMSA

Holds First Government Relations Day

More than 100 Michigan physicians, auxilians and legislators gathered in Lansing November 16 for the first annual MSMS/MSMSA Government Relations Day. The purpose of the event was to bring Michigan physicians and auxilians together with their legislators to lobby for passage of two pension protection bills — SB 261 and HB 4666. The passage of these bills was the primary MSMS legislative goal during the fall. Photo highlights of the event follow.

Mitchell A. Rinek, MD, (right), chairman, MSMS Committee on State Legislation and Regulations, discusses his legislative concerns with Rep. James Middaugh (R-Paw Paw).

MSMS Board member B. David Wilson, MD, Kalamazoo (left) takes a moment to chat with Rep. Paul Wartner (R-Portage). Shown in center is Rep. Don Gilmer (R-Augusta).

MSMS Board Chairman Frank B. Walker, MD, and Joyce C. Mann, MSMS Auxiliary president, welcome the more than 100 Michigan physicians, auxilians and legislators who gathered Nov. 16 in Lansing for the first annual MSMS/MSMSA Government Relations Day.

Rep.-elect Nancy Crandall (R-Muskegon) and Donald K. Crandall, MD, Muskegon, (center) share some of their thoughts with Rep. Ken Sikkema, (R-Grand Rapids).

Jerry H. Rosenberg, MD, Southfield, (right) listens intently to Rep.-elect Jan Dolan, (R-Farmington).

A LOOK BACK AT THE FOUNDING OF

U-M'S RACKHAM ARTHRITIS RESEARCH UNIT

By Joel D. Howell, MD, PhD

In 1937 Walt Disney released *Snow White and the Seven Dwarfs,* and Ernest Hemingway published *To Have and Have Not.* One still did not have to provide a number when speaking of the "World War." The Golden Gate Bridge opened, and Joe Louis regained his heavyweight crown.

The State of Michigan celebrated 100 years of statehood, and the University of Michigan celebrated 100 years in the city of Ann Arbor. The UM Medical School welcomed 138 students, each of whom paid a $110 in-state, or $175 out-state, tuition fee per semester. Almost 45 percent of the students worked part-time to support themselves. Cyrus Sturgis was firmly in the chair of internal medicine, a position he had held since 1928. And, on June 17, 1937, the Horace Rackham Fund gave the University of Michigan one million dollars to found an arthritis research unit.

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During the 1930s, there was little support for medical research and few units existed for the study of rheumatic diseases. This article will provide a detailed look into the national and local context within which the Unit was born, and the importance of early-20th century philanthropy for medical research, particularly for the Rackham Unit.

Arthritis in the 1930s

Ideas about arthritis were somewhat different in 1937 than those we hold today. At the Fourth Annual Meeting of the American Association for the Study and Control of the Rheumatic Diseases, Philip Hench commented on the effects of jaundice on arthritis. His observations led to studies that would culminate a decade later in the discovery of cortisone. But not yet. Physicians suspected that gout was related to uric acid, but were not sure exactly how.

The study of arthritis was dominated by the study of microbiology. This emphasis made sense, especially if one looked back, in 1937, at the tremendous advances that had been made during the preceding 50 years in the identification and control of infectious diseases. One popular theory related systemic arthritis to focal bacterial infection. Innumerable teeth, tonsils, and gallbladders were sacrificed at this theory's altar; as many as one-third of all tonsillectomies done in the US were performed to cure rheumatoid arthritis. Researchers looked for — and found — evidence of bacterial infection in the blood and joints of people with rheumatoid arthritis. Some microbiological research led to therapy we still use, even though we might now disagree with the theory on which that therapy was originally based. In general, there was agreement that rheumatoid arthritis was caused by some kind of bacterial infection; that it was a major cause of morbidity; and that little could be done to treat the disease.

Horace Rackham and his Fund

Born to modest means in 1858, Horace Rackham became a lawyer. In 1903, he filed incorporation papers for a new Detroit company, the Ford Motor Company. Rackham was paid $50 to file the papers. He also received the right to purchase stock in the new company and borrowed $5,000 to invest, over the discouraging words of a bank officer who said: "Even the bicycle has yet to displace the horse." I know not what became of the bank, but in 1919, when Henry and Edsel Ford bought out private shareholders, Rackham's initial investment had brought in some $2 million in dividends and was worth $12.5 million — an enormous sum in 1919.

Rackham took seriously the social responsibility of his newly-found wealth. He supported the local community and the University of Michigan, giving the latter $600,000 for scholarships.

Despite his large-scale philanthropy while he was alive, his estate was worth $16.5 million when he died in 1933. After a substantial amount was distributed to Rackham's wife and friends, the Rackham Fund was established in 1934 with assets of $14,215,000.

Even though Horace Rackham had no university education himself, over $9.6 million of his fund eventually went to the University of Michigan. The first major donation came in 1935, when the Rackham Fund gave $4 million to endow the "very heart" of the University," the graduate school, as the Horace H. Rackham School of Graduate Studies. The Fund built a $2.5 million building to serve as the center for the graduate school. The funds also were used for large-scale support of university-wide faculty research.

The funds were to be used for "such benevolent, charitable, educational, scientific, religious, and public purposes as... will promote the health, welfare, happiness, education, training, and development of men, women and children, particularly the sick, aged, young, erring, poor, crippled, helpless, handicapped, unfortunate and underprivileged, regardless of race, color, religion, or station. Rackham left out no one. So why did the fund support the formation of an arthritis research unit?

The answer to this question comes from interrelationships between the lives and diseases of particular individuals. When Mary Horton Rackham, Horace Rackham's wife, needed care for her osteoarthritis, she consulted Carl Badgley, a University of Michigan orthopedic surgeon. Badgley thereby got to know Mary Rackham's brother, Bryson Horton, chairman of the Board of Trustees for the Rackham Fund. When Bryson Horton's wife, Bessie, developed rheumatoid arthritis, she sought help at the University of Michigan. She was told that little was known about the disease, and that nothing could be done since there had been little support for studying diseases that cripple but do not kill, such as rheumatoid arthritis.

Bryson Horton asked Badgley to confer with Sturgis, chairman of the Department of Internal Medicine, to lay out plans for what would be an effectual research program — and not to be too stingy in his request.

Sturgis stated that "the ideal situation would be the donation of a sum not less than $1 million." (Sturgis interestingly cited tuberculosis as an example of the benefits to be derived from intensive medical research on a disease. Although apparently an effective choice, research in medical history now suggests that medicine had little to do with the fall in death rates from tuberculosis.) And so, at their June 1937 meeting, the U-M Board of Regents accepted the $1 million to found the Rackham Arthritis Research Unit, the first wholly new enterprise within the University to be initiated by the Rackham Fund.

What difference Did it Make?

Philanthropic funds were almost the only source of support for physicians wishing to do scientific studies during the 1930s. This support was largely made possible by the dramatic increase in national wealth during the late 19th and early 20th centuries. Most of that wealth came from industry, and the two names most commonly associated with philanthropic foundations are Rockefeller and Carnegie. Although not an industrialist, Rackham's wealth came no less directly from the assembly lines of the Ford Motor Company.

What we now think of as the norm — federal research support — was almost nonexistent. American scientists generally feared governmental control and opposed large-scale federal funding. When the government wanted scientific research, it contracted with its own scientists in its own labs, as it did during the first 50 years of the National Institutes of Health.

In 1938, universities received a total of only $5 million for medical research. Of that, little went for studying chronic diseases, such as arthritis.

The Rackham Arthritis Research Unit was one of very few units devoted to the study of rheumatic diseases. Only three other academic rheumatology units were in operation in 1937 — at Harvard, Columbia, and New York universities. Two of

continued on next page

these three were supported, like the Rackham Unit, by personal gifts.

The Rackham Unit was the first unit wholly devoted to the study of arthritis in a full-time, academic setting. It provided not only funds, but also a stable institution within which to do rheumatology research, and in so doing, helped define the field of rheumatology.

Over the past 50 years, the Rackham Unit has been home to five American Rheumatism Association presidents: Richard Freyberg, William Robinson, Charley Smythe, Giles Bole, and William Kelley.

The Past 50 Years

Janus-like, 1937, is a good year from which to look forward as well as back. Back to theories and research based on microbiology, and to support from enlightened industrialists. Forward to biochemistry and molecular biology, and to federal support. For in 1937 there were the first glimmerings of a revolution in research support, a revolution that would enable the Unit to survive the eventual cessation of philanthropic funds.

Previously, the federal government had no mechanism for providing extramural support. But the National Cancer Institute was created in 1937, in an enormously popular bill that was co-sponsored by every senator and that swept through Congress in record time. The bill contained two key elements. First, it established a separate institute for a specific disease, and thus presaged the post-WWII National Institutes of Health. Second, it provided the authority to make extramural grants, an authority assumed by the Public Health Service in1944. The Rackham Unit quickly requested and received federal research support.

The late 1940s and the early 1950s were exciting times for rheumatology. In 1948, Charles Ragan and his colleagues described the rheumatoid factor, and Malcolm Hargraves published his description of the lupus erythematosus cell. In 1949, Hench, Philip Kendall, and their co-workers described the use of steroids to treat rheumatoid arthritis. Although steroids proved not to be useful for long-term therapy, the fact that this disease could be treated at all provided a tremendous boost to rheumatology. In 1950, the National Institute of Arthritis and Metabolic Diseases was founded (the precursor of the present National Institute of Arthritis and Musculoskeletal and Skin Diseases), and it started to provide research support the next year.

Like many other institutions, the Rackham Unit benefited from the increased national interest and support. By 1958, grants provided four times as much as their original endowment, then supplying $48,000 per year. By 1962, total support had risen to $500,000, of which around $60,000 was from Rackham Funds. The Rackham Unit had become a nationally recognized center of excellence, thanks in large part to the roughly $1.5 million the Unit received from the fund. In 1965, when the Rackham Board of Directors decided to phase out long-term support from all existing units, the Unit could survive in the new environment. It now receives almost $1 million per year in federal funds. ■

Doctor Howell is assistant professor, Department of Internal Medicine, U-M Medical Center. References for this article are available from the author upon request.

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EQUAL HOUSING LENDER

Health Claims on Food Labels

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The basis of good nutrition is moderation in intakes of carbohydrates, protein, fat, minerals and vitamins provided by a variety of foods. In practice, sound nutrition is not sensational nor does it claim to cure disease. On the other hand, the promoters of health foods often promote and profit from literature making sensational health claims. However, in the past, such claims could not appear on the label. But this may end soon as the Food and Drug Administration (FDA) gets ready to release its new "health claims on food labels" rule. Although, the new rules are not yet final, the FDA appears to be relaxing its current legislation.

Food, Drug and Cosmetic Act

Under provisions of the Food, Drug and Cosmetic Act, a drug is so called if it can be categorized in one of the following four ways: 1) is listed in an official formulary; 2) is to be used in the diagnosis, cure, mitigation, treatment or prevention of disease in man or animals; 3) is an item (other than food) which will affect the structure or any function of the body of man or animals and 4) is an item intended for use as part of any of the above. There is an exception for food under number three above, but if a food is labeled as a curative or prevention agent, it would be classified as a drug under the current Act (1). While it is evident that food does play a role in the prevention and treatment of disease as part of the overall diet, making a health claim for one food may currently cause it to be viewed as a drug. Drugs must undergo rigorous testing in controlled studies to ensure that they are safe and effective. This is the major reason for the food industry's interest in the re-examination of the existing law. The FDA, under the current law, has prevented foods from carrying therapeutic claims on their labels.

However, Victor Herbert, MD, JD, president of The National Council against Health Fraud, has pointed out that the current Food, Drug and Cosmetic Act does not prohibit responsible statements on food labels. He gives a sample statement which would not violate the current law: "The National Cancer Institute suggests Americans should eat not less than 20 and not more than 35 grams of a variety of fibers from an assortment of grains, fruits and vegetables. One portion of Kellogg's All-Bran® contains 9 grams of one form of fiber; wheat bran fiber."

Currently, promoting the health aspects of a food is good business. Public interest groups who have promoted health claims on labels because of a desire to have more nutrition information available to the public now fear inappropriate health claims by the manufacturers. For example, under the proposed new ruling, it may be possible to promote a food which is high in fat or cholesterol, on the basis of its high fiber content.

The Attorney Generals of seven states strongly oppose the new legislation. They claim that it would be difficult for states to enforce the legislation. These Attorney Generals also point out that there are better ways to convey health-related information to consumers than through health claims on food labels.

Implications for education

The use of nutrition labels on food packages was initiated in the mid-1970's. This permitted consumers to determine their intakes of some nutrients from a serving of food. Over the years, the public has learned to believe in the "nutrition label" on the food package. Specific information on the label such as the amount of sodium or the amount and types of fat in the product has been beneficial for those interested in controlling intakes of such nutrients. Health professionals have learned to use the "nutrition label" on foods to help educate their clients.

Expanding the nutrition information on the food label to include health claims expands the function of the food industry to include education about clinical nutrition issues. Thus, the industry must be held responsible for truthful education as are physicians and dieticians who teach clients about nutrition. Health and disease-related claims on the food label could misinform the public by the omission of information or by implication. For example, some foods are advertised as "low in cholesterol" with the implication for the uninformed or partially informed consumer that cholesterol is the only important dietary factor in the etiology of heart disease. In fact, there are two other dietary factors which would be more apt to reduce risk for heart disease than a reduction of dietary cholesterol. These are weight loss, if overweight, and a reduction of the percentage of dietary energy (kcal) which comes from fat. Consumers who associate "low in cholesterol" with reduction in risk for heart disease would be misled, if the food were high in fat or kcal or both. Thus, physicians and other medical personnel (Clinical and Community Dieticians) must be knowledgeable about how the client interprets health claims on food labels and be ready to correct misleading implications. Limited space on the food package makes it unlikely that the complexity of the diet-disease relationships could be fully explained on a food label.

Variety for nutritional adequacy

From dietary surveys, it is obvious that people who consume a variety of foods, compared to those with narrow food choices, are more likely to consume adequate amounts of the 40 plus nutrients necessary for good health. Thus, health professionals support the use of a varied diet, in order to assure an adequate intake of all nutrients. Reliance on a few foods, promoted on the basis of health and disease-reduction claims on food labels, could weaken a concept, commonly taught, that people should consume a variety of foods.

Even more alarming than health claims on food labels, is the report from the FDA that the dietary supplement industry is interested in promoting health and disease-specific claims for vitamins and minerals. Such claims for supplements could weaken even further the concept of the use of a variety of foods each day.

Scientific aspects of health claims

A consistent body of reliable scientific evidence would be necessary to establish a health claim for a specific food or nutrient. Due to biological and other differences, the results of an experiment frequently cannot be extrapolated beyond the species, age, length of time the experiment was conducted or other experimental conditions. Thus, controversial or seemingly controversial reports are common in the literature. Continued scientific investigation must be done to resolve these issues. Aggressive marketing of food by using health claims on food labels could easily result in erroneous nutrition information which, over time, would have to be modified or even reversed.

Conclusion

In our opinion, the best health claim policy cannot be developed, administered and enforced given the budget of the FDA. Even if there were no financial restraints, the practicality of developing scientifically accurate and timely information would be difficult. In addition, it would be necessary to assure that the public received appropriate information in the limited space available on the label and interpreted it in relationship to the use of a varied diet. ■

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MSMS

holds workshop for young physicians

The MSMS Young Physician's Section, in cooperation with Physician Service Group Inc., an MSMS subsidiary, held a one-day workshop on "Financial and Medical Practice Management" Oct. 6 in Dearborn. The workshop, tailored for young physicians and senior residents, addressed topics such as evaluating a practice opportunity; evaluating contracts, malpractice coverage and asset protection; alternative healthcare finance systems; the political future and economic climate for young physicians in Michigan; selecting professional advisors; tax planning; and retirement planning. Photo highlights of the event follow.

Nearly 100 young physicians and senior residents from around the state gathered in Dearborn for the day-long workshop on financial and medical practice management. The workshop featured seven educational sessions and speakers.

MICHIGAN
MEDICAL

Curt DeRoo, a partner with Kerr, Russell and Weber, Detroit, discusses evaluating contracts, malpractice coverage and asset protection.

James V. Buzzitta, MD, Grand Rapids, (far left), and Thomas J. Archambeau, MD, Lansing, (second from left), both members of the Program Committee for the workshop, take a moment to chat with Kristine Manoogian (second from right) and Mary Ellen McLean, both marketing representatives for MPMLC/Stratton-Cheeseman Management Co.

MICHIGAN ST
MEDICAL SOC

Marguerite R. Shearer, MD, Ann Arbor, a member of the MSMS Board of Directors, reviews alternative healthcare finance systems.

State Representative James A. Kosteva (D-Canton), featured luncheon speaker, discusses the political future for young physicians in Michigan.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

James E. Adisey, MD — IM
15261 Eastburn Ave.
Detroit 48205

Sajida A. Ahmed, MD — OBG
212 W. Sixth St.
Clare 48617

Mohamed K. Ajjour,MD — IM/CD
25910 Kelly Rd. #C
Roseville 48066

Jeff A. Alexander, MD — GE/IM
560 W. Mitchell
Petoskey 49770

Alice F. Andrews, MD — PD/NPM
1840 Wealthy St., SE
Grand Rapids 49508

Mark M. Bajorek, MD — FP
775 S. Main St.
Chelsea 48118

Stephen D. Barbour, MD — PD/ID
8355 Baileau Oaks, NE
Ada 49301

C. Richard Barnett, MD — FP
617 Second Ave.
Lake Odessa 48849

K.L. Bergsman, MD — IM/HEM/ON
18700 Meyers Rd.
Detroit 48235

Mark J. Bielaczyc, MD — AN
416 Connable
Petoskey 49770

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Lansing 48909

James K. Brasseur, DO — FP
1520 N. Michigan Ave.
Saginaw 48602

Richard G. Campbell, MD — FP
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2740 28th St., SW
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3420 Lincoln Rd.
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Tawas City 48763

Anne Eisen, MD — P
603 Spring St.
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S. Christopher Ellis, MD — AN
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Grand Rapids 49503

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Flint 48505

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Southfield, MI 48075

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Belmont 49506

R. Arthur Gindin, MD — NS
560 W. Mitchell
Petoskey 49770

Alan P. Goldberg, MD — IM
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Flint 48532

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St. Joseph 49085

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Swartz Creek 48473

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St. Joseph 49085

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Traverse City 49684

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Canton 48187

Michael M. Kaplan, MD — IM/END
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Southfield 48034

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18700 Meyers Road
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Grand Rapids 49506

continued on next page

Continued from page 43

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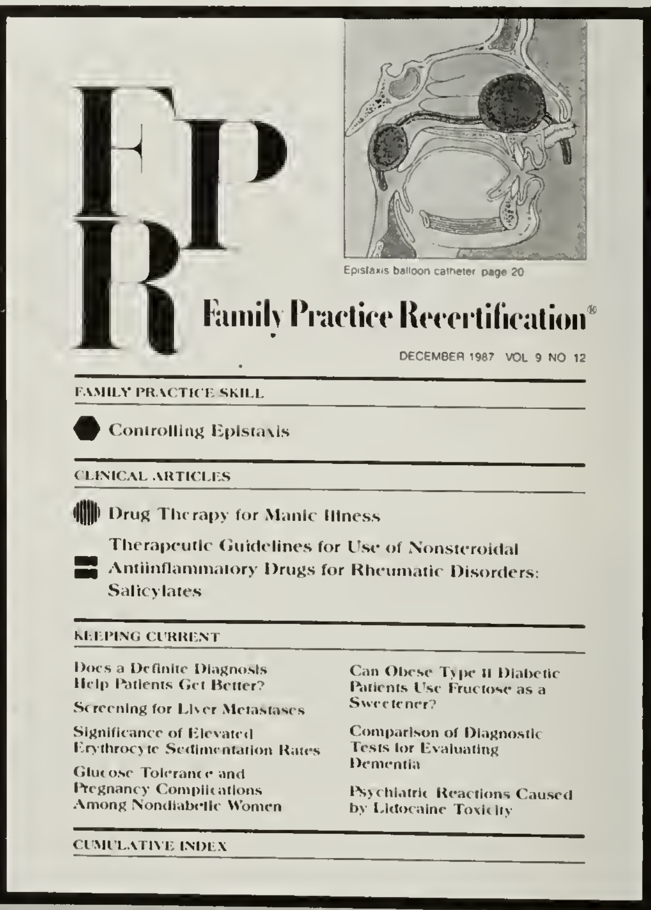

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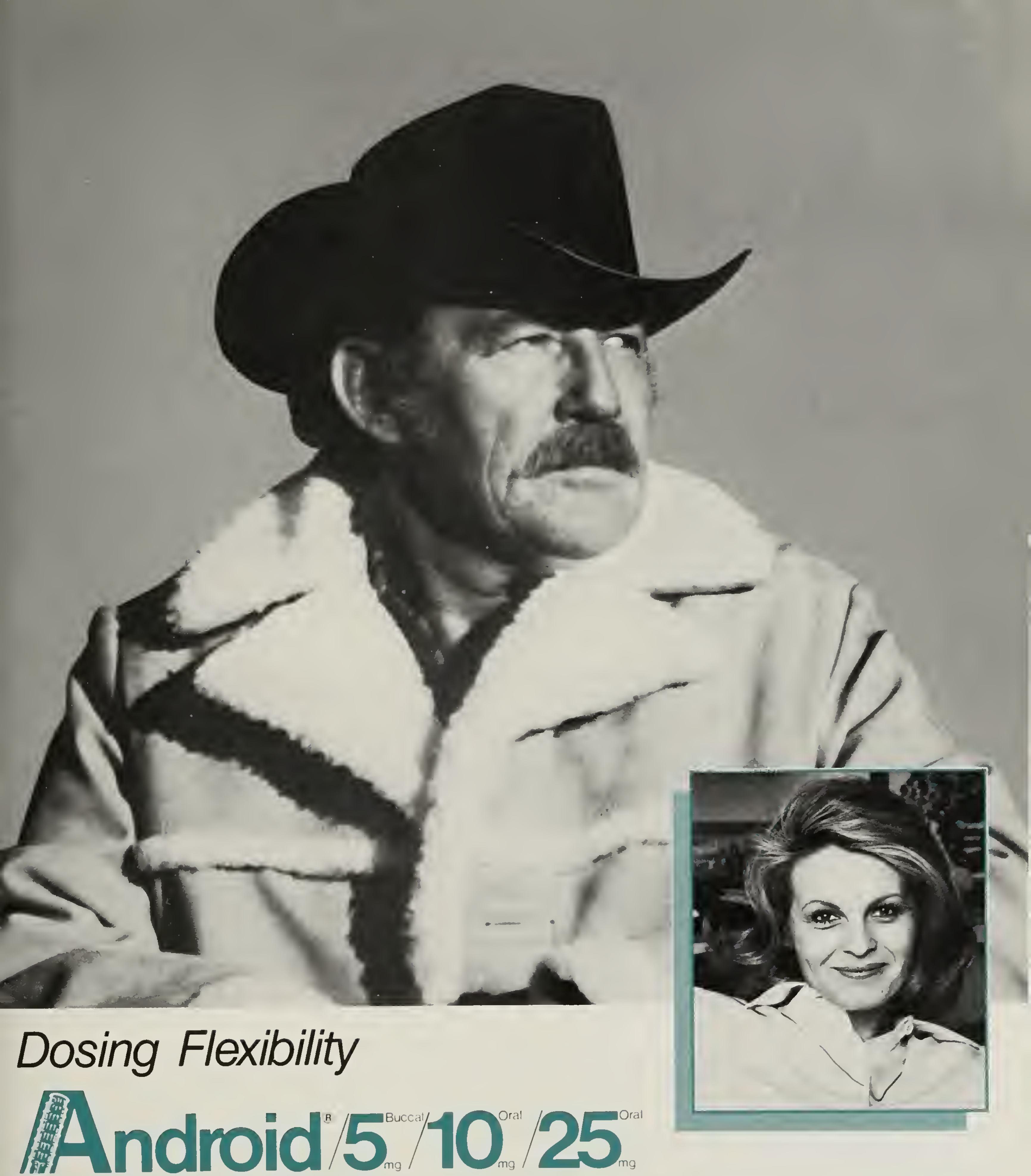

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DEATHS

Ralph M. Gignac, MD
Wayne

Doctor Gignac, a general practitioner, died September 13 at the age of 76. A 1937 graduate of Wayne State University School of Medicine, Doctor Gignac was a member of the Washtenaw County Medical Society. He earned the rank of major in the US Air Force.

Howard A. Burrows, MD
Dearborn

Doctor Burrows, a general practitioner and surgeon who practiced in Dearborn for 50 years, died September 27 at the age of 90. He received his medical degree from Boston University Medical School in 1924. He was a member of Wayne County Medical Society.

Lloyd S. Dunkin, MD
Greenville

Doctor Dunkin, an anesthesiologist and general practitioner, died October 18 at the age of 90. He received his medical degree from Wayne State University School of Medicine in 1921. He was past-president of the Ionia Montcalm Medical Society, and was a member of the American Society of Anesthesiology and of the American Medical Association. Doctor Dunkin served as lieutenant colonel in the US Army during 1942-1946.

Robert R. Howlett, MD
Grayling

Doctor Howlett, a general practitioner, died September 25 at the age of 83. A 1939 graduate of the University of Michigan Medical School, he was on staff at Caro Community and Saginaw General hospitals. Doctor Howlett served as president of Tuscola County Medical Society in 1940, 1943 and 1963. He was a veteran of WWII, having served as a lieutenant commander in the US Navy.

Charles L. Schneider, PhD, MD
Dearborn

Doctor Schneider, a Dearborn gynecologist/obstetrician for 35 years, died last August at the age of 75. A diplomate of the American Board of Obstetrics and Gynecologists, Doctor Schneider published 110 research papers. He was a retired professor emeritus at the University of Michigan Laboratory at Wayne County General Hospital. He was a member of the Wayne County Medical Society, the German Gynecologic Society, American College of Obstetrics and Gynecology and the American Physiologic Society.

Daniel R. Scholes, MD
Troy

Doctor Scholes, a retired surgeon at Beaumont Hospital, Royal Oak, died September 20 at the age of 73. A 1942 graduate of the University of Michigan Medical School, he practiced general surgery in Birmingham and Royal Oak and was on staff at Harper Hospital before going to Beaumont in 1953. He was a member of the International College of Surgeons and of the Oakland County Medical Society.

Rebbeca B. Aquino-Clark, MD
Grosse Pointe Park

Doctor Aquino-Clark, a native of the Philippine Islands, died September 23 at the age of 62. A graduate of the University of Santo Tomas, Manila, she attended the University of Michigan. She worked at Alexander Blain Hospital in Detroit where she specialized in internal medicine. Doctor Aquino-Clark was a member of the Philippine Medical Association, the Bataan Association of Michigan, and the American Medical Association.

William G. Self, MD
Grosse Pointe

Doctor Self, a chief surgeon at Saratoga General Hospital for 15 years, died September 2 at the age of 76. A 1940 graduate of New York University, Doctor Self was a member of the American Academy of Surgeons, Detroit Academy of Surgery, Detroit Surgical Society, the Wayne County Medical Society and the American Medical Association.

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MEETINGS

MSMS Meetings

January

18, MSMS Board of Directors Meeting, MSMS headquarters, Contact: William Madigan (517) 337-1351.

March

2, First Annual MSMS Young Physicians Section Meeting, Lansing Sheraton Inn, Dearborn, Contact: Linda Munson, MSMS Young Physicians Section, (517) 337-1351.

8, MSMS Board of Directors Meeting, MSMS headquarters, Contact: William E. Madigan (517) 337-1351.

11, Fourth Annual MSMS Hospital Medical Staff Section Meeting, Ritz Carlton Hotel, Dearborn, Contact: F. B. "Tom" Plasman, MSMS Hospital Medical Staff Section, (517) 336-1351.

17-18, MSMS Section for Graduates of Foreign Medical Schools Organizational Meeting, Ritz Carlton Hotel, Dearborn, Contact: Judith E. Marr, MSMS Section for Graduates of Foreign Medical Schools, (517) 337-1351.

22-23, Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyond The Horizon" Hyatt Regency Dearborn, Contact: Sherry L. Fent.

May

5-7, MSMS Board of Directors and House of Delegates, Hyatt Regency Dearborn, Contact: William E. Madigan (517) 337-1351.

AMA Meetings

January

27-28, AMA and the University of Texas, "Tobacco Use in America," Houston, Texas, Contact: Bill Silberg (312) 645-4417 or Jane Brust (713) 792-3030.

Michigan Specialty Society Meetings

January

19, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, Contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

20-21, Michigan Psychiatric Society, Embassy Suites Hotel, Southfield, Contact: Mary Jane Muysenberg, 21700 Northwestern Highway, Suite 1150, Southfield, MI 48075-4999 (313) 552-8666.

28, Michigan Allergy Society, Holiday Inn, Livonia West, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

February

16, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, Contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

March

16, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, Contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

April

20, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, Contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

May

4-5, Michigan Chapter, American College of Surgeons, "Coller Day Competition and Scientific Session" Sheraton University Inn, Ann Arbor, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

8-10, MSMS Auxiliary Annual Session, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

National Specialty Society Meetings

January

20-23, American Diabetes Association, Postgraduate Course of the American Diabetes Association, Loews Anatole Hotel, Dallas, TX Contact: (703) 549-1500.

22-26, American Association for Cancer Research, Second AACR Special Conference in Cancer Research: The Role of DNA Viruses in Human Tumors, Catamaran Resort Hotel, San Diego, CA Contact: (215) 221-4565.

February

5-8, American Society for Parenteral and Enteral Nutrition: 13th Clinical Congress, Fontainebleau Hilton, Miami Beach, Contact: A.S.P.E.N. 8605 Cameron Street, #500, Silver Spring, MD 20910 (301) 587-6315.

9-14, American Academy of Orthopaedic Surgeons Annual Scientific Meeting, Las Vegas, NY, Contact: American Academy of Orthopaedic Surgeons, 222 S. Prospect, Park Ridge, IL 60068 (312) 823-7168.

13-18, American Academy of Forensic Sciences, 41st Annual Scientific Meeting of AAFS: Serial Crime, Lab Safety, Riviera Hotel, Las Vegas, NV, Contact: (719) 636-1100.

24-3/1, American Academy of Allergy and Immunology Annual Meeting, Convention Center, San Antonio, TX, Contact: American Academy of Allergy and Immunology, 611 E. Wells St., Milwaukee, WI 53202 (414) 272-6071.

March

2-5, American College of Nuclear Physicians Annual Scientific Meeting, Sheraton Bal Harbour, Bal Harbour, FL, Contact: American College of Nuclear Physicians, 1101 Connecticut Avenue, N.W., Suite 700, Washington, DC 20036 (202) 857-1135.

5-10, American Society For Neurochemistry, 1989 Annual Meeting: Research Communications and Symposia on Various Aspects of Neurochemistry, Hyatt Regency Hotel, Chicago, IL, Contact: (416) 962-1155.

8-10, American Society For Clinical Pharmacology and Therapeutics, 90th Annual Meeting, Opryland Hotel, Nashville, TN, Contact: (215) 825-3838.

11-16, American Society of Clinical Pathologists: College of American Pathologists, 1989 Annual Meeting, Hyatt Regency Hotel, Chicago, IL, Contact: (312) 738-1336.

19-23, American College of Cardiology Annual Scientific Meeting, Hilton Inn, Anaheim, CA, Contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 (301) 897-5400.

19-24, American Association of Pathologists Annual Meeting, New Orleans, LA, Contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814 (301) 530-7130.

19-24, American Institute of Nutrition, 1989 Annual Meeting, New Orleans, LA, Contact: (416) 962-1155.

31-4/4, American Orthopsychiatric Association, 66th Annual Meeting, New York Hilton, New York, NY, Contact: (212) 354-5770.

April

2-6, American Association of Neurological Surgeons Annual Meeting, Washington, DC, Contact: American Association of Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, Il 60068 (312) 692-9500.

4-6, American Laryngological, Rhinological and Otological Society Annual Scientific Meeting, Fairmont Hotel, San Francisco, CA, Contact: The Triological Society, P. O. Box 155, East Greenview, PA 18041 (215) 679-7180.

12-16, American College of Preventive Medicine Annual Scientific Meeting, Westin Hotel, Atlanta, GA, Contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202) 789-0003.

13-16, American College of Physicians Annual Meeting, San Francisco, CA, Contact: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104 (215) 243-1200.

13-19, American Academy of Neurology Annual Scientific Meeting, Hynes Convention Center, Chicago, IL, Contact: American Academy of Neurology, 2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612) 623-8115.

29-5/5, American Occupational Medical Association Annual Scientific Meeting, Sheraton Boston, Boston, MA, Contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312) 228-6850.

May

6-12, American Psychiatric Association Scientific Meeting, San Francisco, CA, Contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005 (202) 682-6000.

7-10, American Association of Plastic Surgeons Annual Meeting, Camelback Inn, Scottsdale, AZ, Contact: American Association of Plastic Surgeons, The John Hopkins Hospital, 601 N. Wolfe Street, Harvey 811, Baltimore, MD 21205 (301) 669-7601.

7-11, American Urological Association Annual Meeting, Infomart/Loews Anatole Hotel, Dallas, TX, Contact: American Urological Association, 1120 N. Charles Street, Baltimore, MD 21201 (301) 727-1100.

8-10, American Association for Thoracic Surgery Annual Meeting, Sheraton/Hynes, Boston, MA, Contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

13-17, American Society for Gastrointestinal Endoscopy Annual Scientific Meeting, Sheraton Hotel, Washington, DC, Contact: American Society for Gastrointestinal Endoscopy, Thirteen Elm Street, Manchester, MA 01944 (617) 927-8330.

13-19, American Gastroenterological Association Annual Scientific Meeting, Sheraton Washington and Shoreham Hotels, Washington, DC, Contact: American Gastroenterological Association, 6900 Grove Road, Thorofare, NJ 08086 (609) 848-1000.

14-17, American Thoracic Society Annual Scientific Meeting, Convention Center, Cincinnati, OH, Contact: American Thoracic Society, 1740 Broadway, New York, NY 10019 (212) 315-8778.

22-25, American College of Obstetricians and Gynecologists Annual Meeting, Convention Center, Atlanta, GA, Contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024 (202) 638-5577.

28-31, American Pediatric Surgical Association Annual Meeting, Hyatt Regency Inner Harbor, Baltimore, MD, Contact: American Pediatric Surgical Association, Johns Hopkins Hospital, Baltimore, MD 20105 (301) 955-6256.

Other Meetings

February

8-10, Management Skills and Techniques for New First-Line Supervisors, Grand Rapids, Michigan, contact: Clark E. DeHaven, Director of Executive Programs, Michigan State University, 7 Olds Hall, East Lansing, MI 48824-1047 (517) 353-8711.

27-28, Planning & Managing Warehouse Operations, Troy, Michigan, contact: Clark E. DeHaven, Director of Executive Programs, Michigan State University, 7 Olds Hall, East Lansing, MI 48824, (517) 353-8711.

27-3/1, Techniques, Technologies, & Tools for Trainers, University of Michigan-Dearborn, contact: University of Michigan-Dearborn, Education and Training Center, 19310 Ford Road, Dearborn, MI 48128 (313) 271-0909.

April

17-18, Thirteenth Annual Conference of the Michigan Association for Infant Mental Health: Expanding Our Approaches with Families — Attachment, Intervention, and Social Policy, Ann Arbor, contact: Ann Saffer, 2340 Hickman Road, Ann Arbor, MI 48105 (313) 994-8168.

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CATEGORY I COURSES

January

13, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 5 hours Category I Credit.

14-15, Advanced Cardiac Life Support Provider Course. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Karen Brown, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 16 hours Category I Credit.

29-2/3, The Thirteenth Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbor Springs. Sponsor: University of Michigan Medical School, Department of Family Practice with the Michigan Academy of Family Physicians, and Department of Postgraduate Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 20 hours Category I Credit.

February

5-10, Fourteenth Annual Seminar on Emergencies in Medicine. Location: Boyne Highlands Ski Lodge, Harbor Springs, Michigan. Sponsor: Detroit Receiving Hospital. Contact: Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. Approved for: 25 hours Category I Credit.

13-17, Eighth Postgraduate Course on Myocardial Infarction and Angina Pectoris. Location: Convention Center, Davos, Switzerland. Sponsor: University of Michigan Medical School, Hanover Medical School, Hanover, West Germany. Contact: Karen McCalla, Marketing Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 28 hours Category I Credit.

March

8-10, A Symposium in Diabetes Care. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School and American Diabetes Association. Contact: Betty Phillips, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 20 hours Category I Credit.

9-14, 12th Annual Ophthalmology: Basic and Clinical Review Course. Location: Wayne State University School of Medicine, Detroit. Sponsor: Kresge Eye Institute of Wayne State University School of Medicine. Contact: Division of Continuing Medical Education, Wayne State University School of Medicine, 4-H University Health Center, 4201 St. Antoine, Detroit, MI 48201 (313) 577-1180. Approved for: 42 hours Category I Credit.

12-14, Family Care: Research & Policy Agendas for the 1990s. Location: Kellogg Center at Michigan State University. Sponsor: MSU College of Nursing, College of Human Medicine, and MSU Family Care Study. Contact: MSU College of Nursing, A-230 Life Sciences Building, East Lansing, MI 48824-1317 (517) 355-6525. Approved for: 12 hours Category I Credit.

14-18, Family Practice-1989 Thirteenth Annual Spring Review Course. Location: Towsley Center, University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Family Practice and the Michigan Academy of Family Physicians. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 34 hours Category I Credit.

22-23, 28th Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyond the Horizon." Location: Hyatt Regency Dearborn. Sponsor: Michigan State Medical Society. Contact: Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P. O. Box 950, East Lansing, MI 48826-0950, (517) 337-1351. Approved for: 12 hours of Category I Credit.

25-4/1, Facial Cutaneous Surgery: Mohs, Reconstructive, Cosmetic. Location: Copper Mountain Resort, Copper Mountain, Colorado. Sponsor: University of Michigan Medical School, Department of Otolaryngology, Head and Neck Surgery. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 30 hours Category I Credit.

continued on next page

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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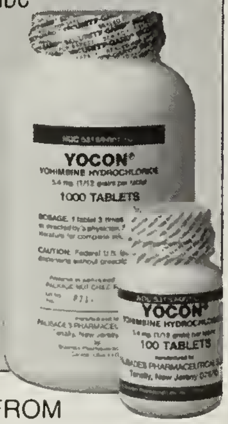

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Continued from page 53

April

3-5, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 22 hours Category I Credit.

13-14, Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 15 hours Category I Credit.

17-19, Contemporary Concepts in Total Joint Replacement. Location: The Sonesta Beach Hotel & Spa, Bermuda. Sponsor: University of Michigan Medical School, Department of Surgery. Contact: Betty Phillips, Pro-

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gram Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 14 hours Category I Credit.

26, Current Women's Health Care Issues. Location: Genevieve U. & Donald S. Gilmore, Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. Sponsor: Southwestern Michigan Area Health Education Center. Contact: Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road, Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. Approved for: 6 hours Category I Credit.

26-28, Advances in Computed Tomography and Magnetic Resonance Imaging. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 22 hours of Category I Credit.

May

11-12, The Restenosis Summit, An International Symposium with Live Demonstrations. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 14.5 hours of Category I Credit.

14, Identification and Diagnosis of Mental Illness in the Developmentally Disabled. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. Sponsor: Southwestern Michigan Area Health Education Center. Contact: Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road-Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. Approved for: 5.5 Category I Credit.

15-19, 17th Annual Spring Update: Advance in Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 34 hours Category I Credit.

19-20, Recent Advances in Cornea, External Disease, and Cataract: 61st Annual Ophthalmology Spring Conference. Location: W.K. Kellogg Eye Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Ophthalmology. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 13 hours Category I Credit.

31-6/2, Current Topics in Blood Banking: 16th Annual Symposium and Workshops. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Pathology. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. Approved for: 12 hours Category I Credit. The Maternal and Perinatal Health Conference Planning Committee

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ORTHOPEDIC SURGEON. A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible orthopedic surgeon to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

PSYCHIATRIST. A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible psychiatrist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (906) 779-4502.

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PRESIDENT'S PAGE

MSMS offers many outstanding educational programs

By Fred W. Bryant, MD

Invariably, it seems, when movies or TV shows are a great success they quickly return unaltered, such as Lassie or MASH, in perpetuity, or are thinly disguised in family form, such as Bride of Frankenstein or Son of Kong, or in numbers, such as Cocoon II or Rambo. In truth, I think you might benefit from hearing, as Paul Harvey is wont to say, "the rest of the story."

Returning to a subject I wrote of in the President's Page only two months ago, we might call this missive, "ASM — The Sequel," or "Siblings of ASM."

MSMS is involved in many education projects. The Annual Scientific Meeting is the biggest in terms of the number of people it attracts. It consists of 55 three-hour courses offered over a three-day period. This year, 14 departments from three medical schools and a dozen departments from nine hospitals combined with more than a score of specialty societies to provide 200 lecturers to instruct 1,000 attendees who accumulated 7,500 CME credit hours. Seventy exhibition booths with 300 exhibitors were on site and a score of clinical posters displayed. A first-time plenary session drew almost 200 people to hear nationally-renowned AIDS expert James Curran, MD, of the Centers for Disease Control, Atlanta. Counting speakers and listeners, almost 1,500 were in attendance.

Other conferences

The Maternal and Perinatal Health Conference in the Spring is a two-day affair which attracts between 700 and 800 attendees — 200 physicians, 400 nurses, and 125 other health care professionals. The program offers 12 CME hours. The caliber and quality of speakers is excellent.

The Annual Conference on Sports Medicine attracts about 200 people, one-third of whom are physicians, the remainder, coaches and trainers. Six instruction hours are credited in the day-long event which is always popular and enhances the physician/trainer relationship.

Through joint sponsorship, largely unsung, MSMS provides an assortment of programs which involve a score of Category I activities with a dozen assorted groups.

Some individual programs involve small medical societies in combination, or large societies alone. From September to September these 28 programs involve 891 doctors and 2,137 Category I CME hours.

The AIDS Speakers Bureau has delivered over 200 programs to more than 17,000 health professionals. PIP (Physicians Issues Presentations) in combination with the MSMS Hospital Medical Staff Section hopes to reach approximately 1,000 physicians by Spring.

All told, MSMS education projects involve 3,000 physicians and 12,000 teaching hours.

Three committees rule over educational programs

Three regulatory committees rule over all educational courses.

The CME Accreditation Committee is supreme, with ultimate jurisdiction over sanctioned projects. Every two to three years, members of the Committee evaluate organizations. They compare Michigan performances to national levels determined by the Accreditation Council for CME.

The CME Programming Committee determines the overall fabric of conferences, sets the tone of various projects and the general outlines for them. Its responsibility is of an umbrella nature.

The ASM Planning Committee provides the direction for specific courses and adds personality and character to the various meetings. Each chairman has added his or her own personal touch to the Annual Scientific Meeting.

Robert F. Wilson, MD, created the Annual Scientific Meeting by bringing together for the first time many concurrent offerings performed by physicians from medical schools and specialty societies. Frank Cox, MD, attracted people from hospital settings. Sam McMahon, MD, introduced the "hands on" practical demonstration sessions and clinics. Ed Cotton, MD, conceived the Alpha-Omega theme for the three-day meeting — to present related courses on successive days. David Rovner, MD, introduced the poster program and encouraged the art of medicine in the face of cold technology. Rudy Ansbacher, MD, urged the multi-disciplinary approach, presenting groups of lecturers with varied backgrounds from different institutions. Last but not least, Joan Stryker, MD, thorough and meticulous, seeks to include something for everyone and to draw residents into the program. The concept of the plenary session is hers.

These leaders have left their imprimatur of excellence on the program by their credos which require: 1) Measurement of medical education credits in terms of benefits to patient care (in contrast to personal gain and self-interest); 2) Faithful adherence to high standards of quality and variety; 3) Unyielding execution of the mechanics of the process in terms of attendance, hourly participation, and evaluation appraisal; and 4) Broadest interests and practicality, "The Clinical Approach." The style of programs they have created fulfill all the criteria, are broadly applicable, conveniently available, reasonable in price, authenticated and verified, and involve local figures available for questioning and comment.

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Doctor Bryant is MSMS president.

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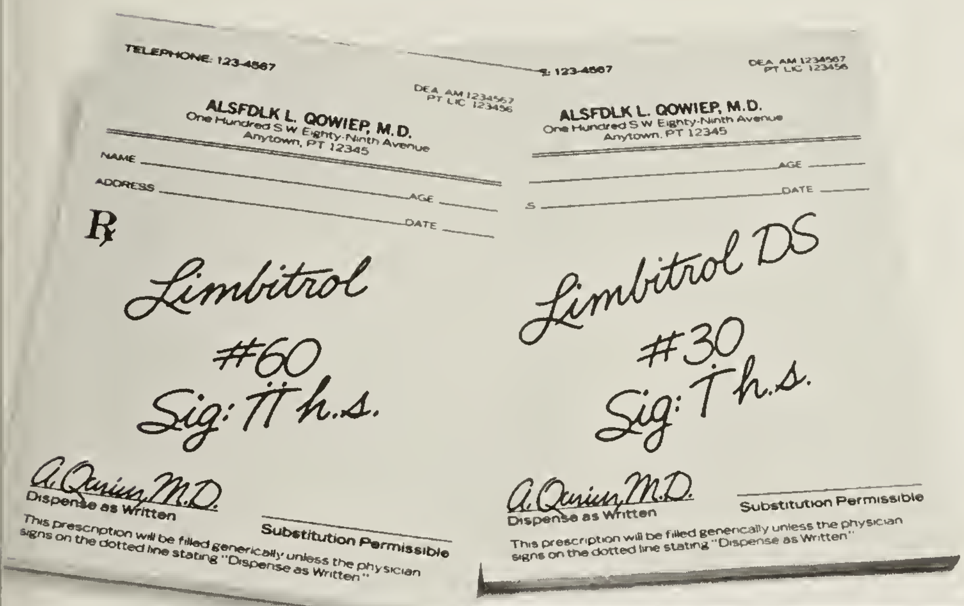
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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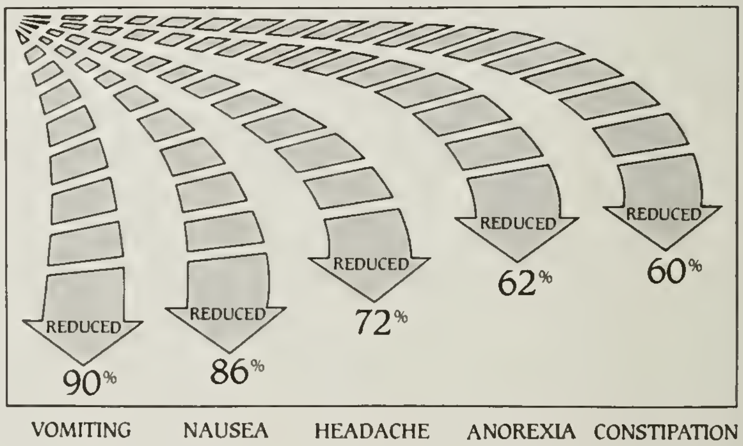
Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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MICHIGAN MEDICINE

FEBRUARY 1989
VOL. 88, NO. 2

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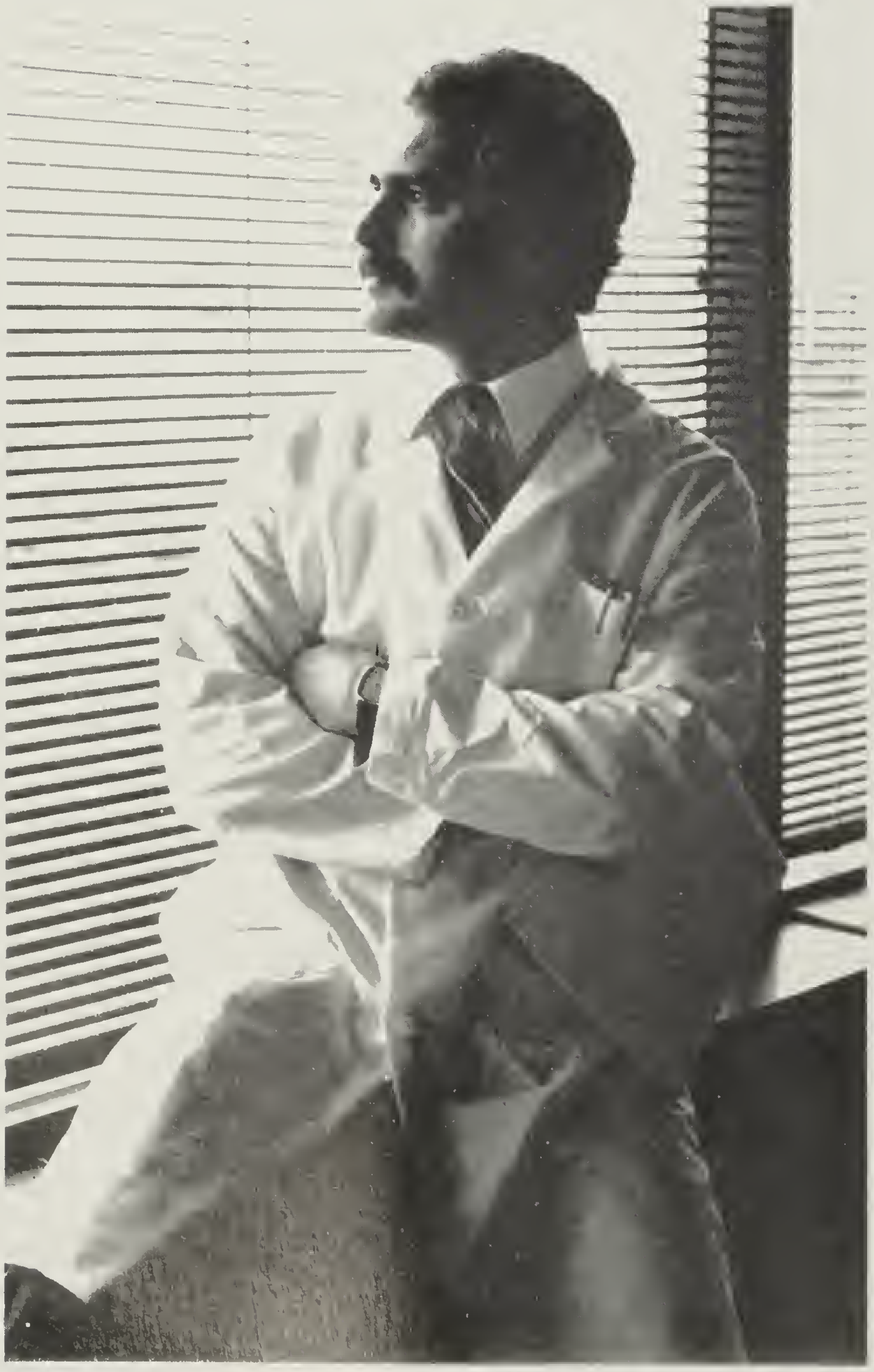

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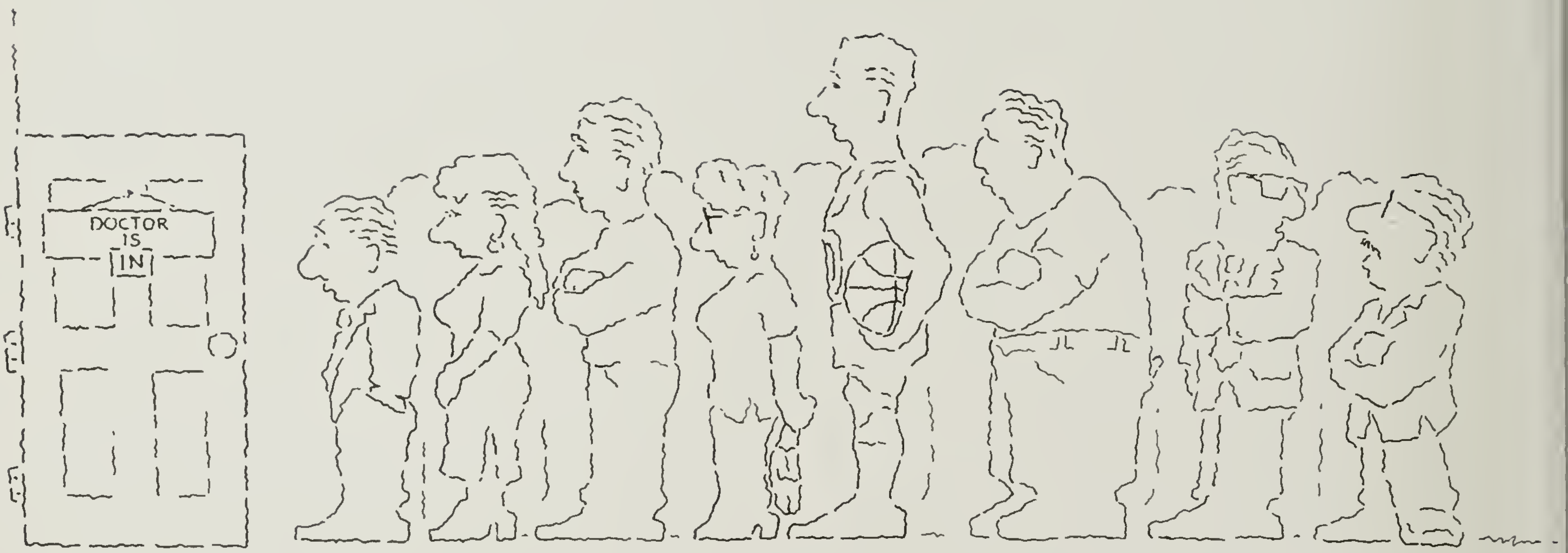

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MICHIGAN MEDICINE

Award-Winning Journal of the Michigan State Medical Society

FEBRUARY 1989
VOL. 88, NO. 2

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Cover Story

The long-awaited Harvard University Resource-Based Relative Value Scale was submitted to the Health Care Financing Administration for review in September 1988. Since that time, interested groups across the country, including the AMA and MSMS, have been analyzing the study and its ramifications. At its December House of Delegates meeting the AMA adopted Report AA, together with its 18 recommendations for implementation should the RBRVS be adopted. Exactly where things stand in regard to the study is the subject of this month's cover story. Frank B. Walker, MD, MSMS board chairman and member of the AMA Board of Trustees, begins the cover story with "a bird's eye view" of the RBRVS. Also included are the AMA's 18 recommendations, printed verbatim from Report AA, and a timetable of sessions scheduled since September to discuss the RBRVS. Both are intended to provide readers with a better understanding of the Harvard study.

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In next month's issue of *Michigan Medicine:* Health Care Delivery to the Elderly.

Cover Illustration By: *Robert L. Brent.*

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS

Administer cautiously to allergic patients

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics It must be considered in differential diagnosis of antibiotic-associated diarrhea Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include

- Gastrointestinal (mostly diarrhea) 2 5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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IN MY OPINION

Health Care To The Elderly Rests With The Private Sector

By John Hall, MD

The members of the MSMS Committee on Publications invite ***Michigan Medicine*** *readers to submit editorials for publication on this page.*

The man on the street and the men in Washington continue to talk about the health care system. Yet, as a provider, I fail to see the continuity that I feel is the characteristic of my definition of a system.

There are three components involved in medical care delivery: the patient, the provider and the payer. Each participates in the planning, decision-making and delivery process, but to varying degrees and with varying levels of influence. No one component has dominance and all lack adequate feedback mechanisms as would be expected in an integrated system.

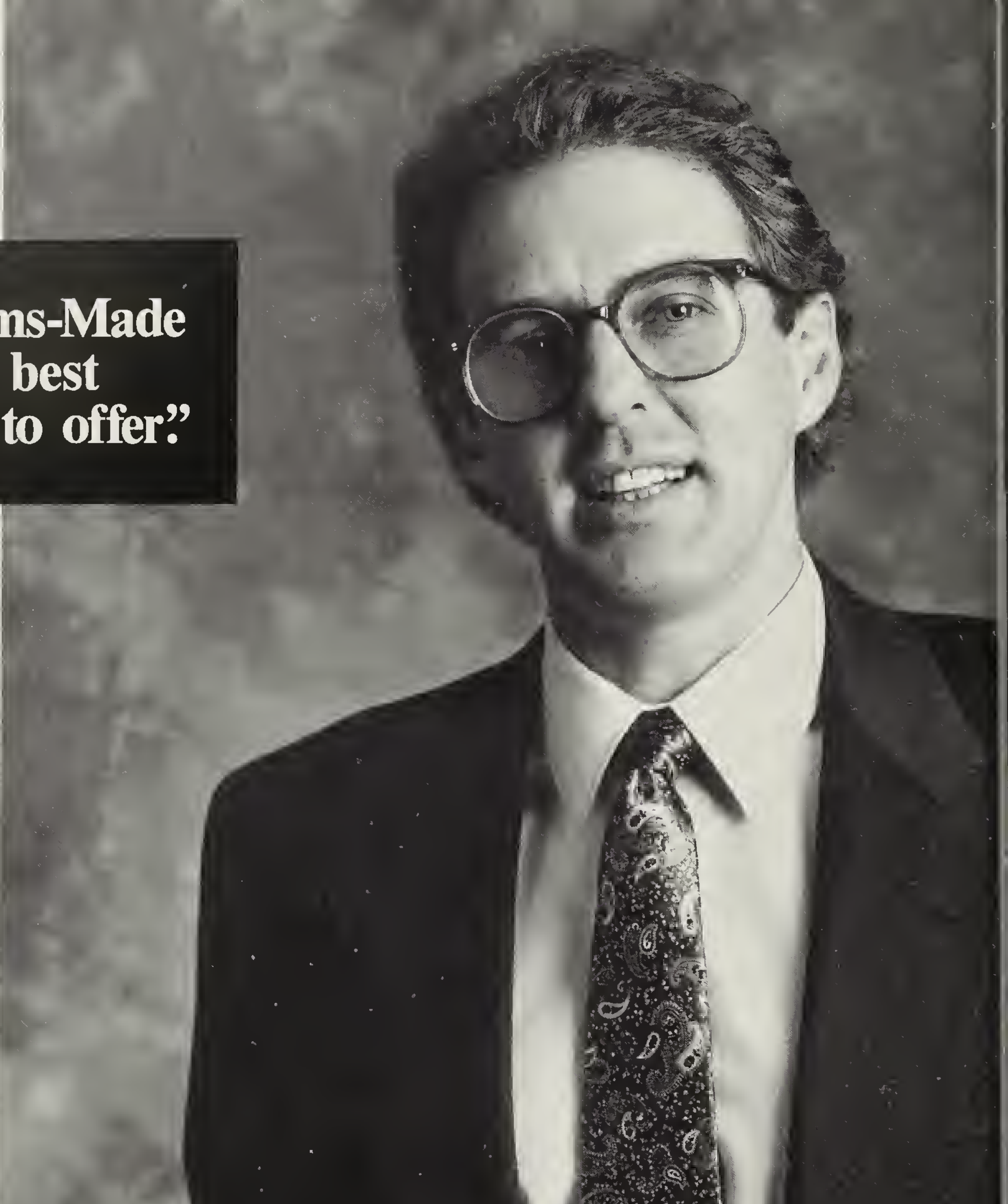
This fall, during the MSMS/Michigan Hospital Association Rural Health Forums, many individuals expressed concern over the lack of coordinated health care delivery to the elderly who live in our rural areas. If we ever saw a need for a systematic approach, it is in this arena. The demands for health care are extensive and the costs are great. Only with effective utilization of services can this care be delivered in an efficient and orderly fashion.

The federal health care planners feel that a national system of health care delivery is the only answer. But, the strength of our health care system has always been in the private sector. Hence, it is imperative that the private sector now mobilize to address this issue.

The hospital is the traditional delivery system for acute care. It is serviced by its medical and nursing staffs. The support services are in place already. Now this system has to be expanded upon to include the systematic delivery of health care service in the ambulatory, post-acute and chronic care areas. Nursing homes, adult foster care homes, home health care nursing services, friendship centers, meals-on-wheels, and other community-based programs have to be brought under the umbrella of the hospital to allow for joint planning and the coordinated delivery of services. The medical care system has to address not only the cure of acute illness but also, all of the long-term health care needs of its citizenry.

With this privately-run but community-oriented approach, we will be able to deliver care efficiently to our aging population. ■

Doctor Hall is a member of the MSMS Committee on Publications.



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Letters from Our Readers

AIDS story disturbing

I read the December issue of *Michigan Medicine*, as I usually do, and was interested in the conference on AIDS, including the AIDS survey. There were several disturbing things, however.

One, as I read the names of the people who were speaking at the AIDS Speakers Bureau Activities Update, I saw that none of them is in the Department of Surgery. These are eight public health people, or infectious disease people; i.e. medical people who are not on the firing line. I think this is a glaring deficiency in not having someone either from emergency medicine or from a surgical specialty involved with this. Certainly the medical workers are at far less risk than are those involved in the operating room or the emergency room.

Two, I think it would behoove everyone involved with the AIDS Education Project to read the commentary article in the December 16 issue of *JAMA*. This was an excellent summary of this problem and its relation to health care workers. While we are talking about educating the populace, we also must see that our health care workers are protected and looked after. Please ask the people involved with this, and with these publications, to read that article, as it says a great deal about the need for protection of health care workers.

Finally, please ask the people who write articles, and speak on this problem, to quit talking about "seroconversion," or "carriers." In the December 1988 issue of *Michigan Medicine*, page 760, Doctor Curran is reported as saying that women are showing up as "AIDS carriers." These people are not just carriers, they are infected; and with our present state of knowledge these people are in the latent phase of the disease and will eventually become active. Thus, to consider them merely as a carrier is incorrect, since once they are positive they are infectious and can transmit the disease.

Loyal W. Jodar, MD
Cheboygan/Petoskey

Medicare provisions explained

Editor's note: The following letter was sent in early December to Michigan Senator Don Riegle, Jr., Flint.

Administrator William L. Roper asked that I thank you for your inquiry on behalf of Robert Paxton, MD, Michigan State Medical Society, who has expressed several concerns about Medicare provisions enacted under the Omnibus Budget Reconciliation Act (OBRA) of 1986.

Doctor Paxton is primarily concerned with the effects of Medicare's Maximum Allowable Actual Charge (MAACs) and the prohibition of billing of services by nonparticipating physicians (physicians who do not agree to accept the Medicare-approved amount as payment in full) determined to be medically unnecessary. As you know, these provisions were enacted by Congress to limit the out-of-pocket expenses to be incurred by Medicare beneficiaries who use the services of nonparticipating physicians and to encourage physicians to elect participation. They have been effective on both accounts. In general, MAACs have been allowed to increase by only about one percent a year, thus limiting beneficiary expenses. The participation rate for physicians has risen from 28 percent in 1986 to 37 percent in 1988, an increase of 32 percent.

It is true that operational problems were initially experienced in enforcing the MAAC limits and also in requesting nonparticipating physicians to refund amounts collected for services subsequently determined to be medically unnecessary. More experience with and the changing of MAAC monitoring by OBRA of 1987 from an average to each individual claim have ironed out most of the operational MAAC-monitoring problems. With regard to the medical necessity denials, carriers have been instructed to request additional information from physicians before denying unassigned claims on this basis.

Doctor Paxton also is concerned that the provisions discussed above and other recent legislation intended to control the rapid rate of increases in Medicare payments for physician services will impede both access to and the quality of services. He cites as the basis for this concern a paper presented by William J. Baumol before the Physician Payment Review Commission (PPRC) on February 11, 1988. We are aware of Doctor Baumol's paper as well as critiques of this paper by several well-known health economists. Without getting into a debate on the merits of Doctor Baumol's conclusions, we would only point out that we have seen no evidence that the cost-containment legislation of recent years has affected either the quality of care or access to care furnished Medicare beneficiaries.

Kathleen A. Buto
Acting Director
Bureau of Eligibility,
Reimbursement and Coverage
Department of Health and Human Services
Washington, DC.

Risk management revisited

Editor's Note: The following letter was sent in early January to Thomas R. Berglund, MD, who is a member of the MSMS Committee on Publications. The letter refers to an "In My Opinion" column Doctor Berglund wrote on risk management. His column appeared in the December 1988 issue of Michigan Medicine.

I enjoyed your recent comments in *Michigan Medicine* on risk management. One thing that I have found particularly useful in this regard, is approaching clinical medicine with a collaborative philosophy that is driven by an educational process. This process begins with patient education and extends on through nursing, physical therapy, and physician colleagues.

Out of this collaborative philosophy, we have developed a process and series of patient and family education monographs, as well as a health care professional primer series. I believe that I have shared examples of these with you in the past, and you will soon be receiving our 1989 calendar that features our first diagnostic primer, "Neurological Localization."

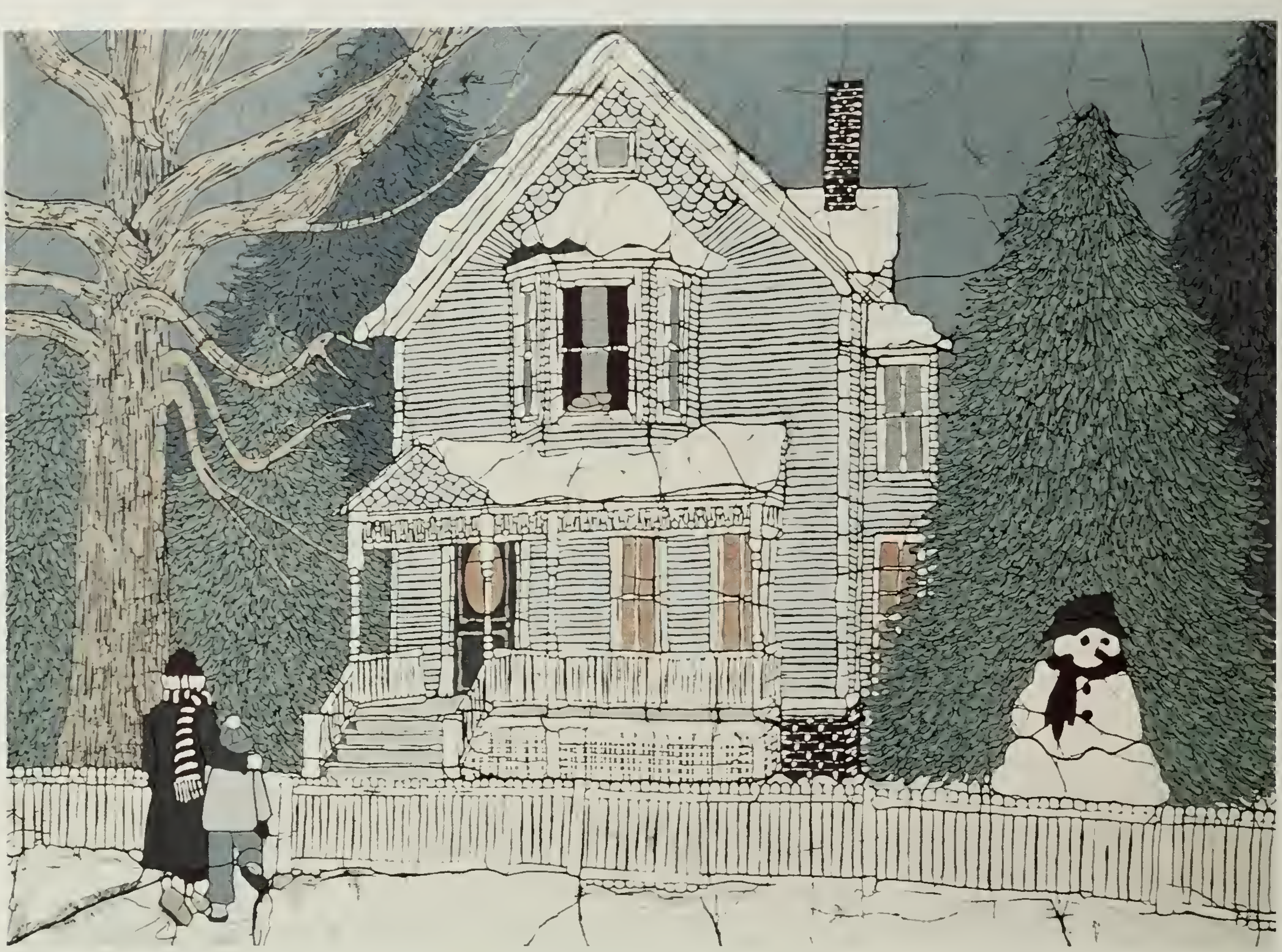
Our philosophy is one of collaboration and teamwork that begins with the patient and family. Our goal is to share the responsibility of the care with the patient and family. In doing so, this obviously requires an intense educational process that we have refined over the past decade.

As an update to the monographs sent to you previously, I am enclosing copies of our newest books in the specialty of neurology. Our materials are used throughout the country in neurosurgery; all of the major departments at Blodgett Memorial Medical Center are currently writing monographs for us in their specialties.

I agree with your comment that risk management has a poor image with physicians. However, if one takes it as a creative opportunity, a communication and educational system can be developed that will not only enhance patient care and recovery, but also will make the practice of modern medicine fun and less threatening. I am very enthusiastic about our project and would be pleased to share it with you at any point in time. My nursing collaborator, Dorothy Bouwman, RN, MSN, and I will be speaking at the Stratton-Cheeseman Risk Management Conference in May on these issues.

Thank you again for your efforts on the part of organized medicine.

Oliver D. Grin, Jr., MD
Grand Rapids



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MEDICAL NEWSFRONTS

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Patients needed for study

Harper Hospital

The Gertrude Levin Pain Clinic, Harper Hospital Professional Office Building, is looking for interested individuals to participate in a chronic low back pain research study.

The use of Trilisate, a medication commonly used to treat arthritis patients, is being studied to treat individuals suffering from chronic low back pain. Those who have had chronic low back pain for at least six months, and do not have significant psychological or drug-related problems, are encouraged to participate.

For more information, contact: Susan Sluis, Pharm. D., Monday through Wednesday, 9 am to 5 pm, at (313) 745-9333.

Beaumont Hospital

William Beaumont Hospital's Clinics of Preventive and Nutritional Medicine need patients for drug studies which are being conducted at Beaumont's clinic in Birmingham.

These studies are for individuals who have high blood pressure, diabetes, high cholesterol or ulcers.

Individuals who qualify to participate in the study will receive free care and medications for the duration of their particpatition.

For more information, call a study nurse at the Beaumont Clinics of Preventive and Nutritional Medicine, (313) 646-6500.

U-M researcher develops blood filter

A University of Michigan research scientist has developed a blood filter that reduces the risk of drug-induced complications after cardiovascular surgery, kidney dialysis and other common clinical procedures.

The filtration device, designed by Victor Yang, assistant professor of pharmaceutics in the U-M College of Pharmacy, removes heparin from the bloodstream of patients undergoing circulatory bypass procedures. According to Doctor Yang, clinical studies show that between eight and 30 percent of all patients who receive heparin develop bleeding complications. Although elderly patients and those with chronic diseases like diabetes are at greatest risk, studies show that heparin also is the major cause of deaths related to the use of therapeutic drugs in patients who were previously healthy.

Doctor Yang's filtration device uses protamine to neutralize heparin, while confining both drugs to blood flowing through the circulatory bypass apparatus only.

Doctor Yang uses a chemical process to bind protamine molecules to fibers from a standard kidney dialysis filter used to remove toxic wastes from the blood of patients with kidney failure.

The filter is inserted in the final section of the bypass apparatus at a point just before blood is returned to the patient. With the filter in place, according to Doctor Yang, large doses of heparin can be administered to prevent clotting as blood enters the bypass equipment. As blood flows through the filter on its way out of the bypass equipment, positively charged protamine molecules in Doctor Yang's filter bind with negatively charged heparin molecules, removing heparin from the bloodstream. Since the protamine molecules remain trapped in the filter's fibers, blood is essentially heparin- and protamine-free when it returns to the patient, preventing complications.

The filter also can be used during kidney dialysis and plasmapheresis. The filter has other applications with external blood-oxygenation devices; during organ transplant surgery; and with experimental artificial heart, lung and liver devices.

The U-M Intellectual Properties Office has patented the blood filtration device.

Specialized care for newborns

Oakwood Hospital, Dearborn, and three Peoples Community Hospital Authority (PCHA) member hospitals — Annapolis, Outer Drive, and Seaway — haved agreed to provide specialized care for newborn babies.

Under the agreement, Annapolis, Outer Drive and Seaway will provide on-call neonatologists around the clock for the three institutions. Oakwood Hospital will supply backup coverage for newborn emergencies.

While Annapolis, Seaway and Outer Drive all have birthing facilities, in the event of an emergency, newborns will be transferred to Oakwood, a 615-bed, full service facility with an established Women and Children's Health Care Center.

New method of testing for viral infections

A Wayne State University biologist has developed a new method of testing for viral infections that eliminates the false-positive and false-negative results that plague currently used tests.

"This technique can detect extremely low levels of antibodies in human serum," said V. Hari, PhD, professor of biological sciences at Wayne State.

The technique involves placing gold molecules on antibodies to detect the virus. Antibodies are produced by the body to attack foreign substances. If the gold-tipped antibodies attach to a cell, the cell vividly shines when viewed through an electron microscope.

Currently used virus-detecting tests use color-development reagents which react with viral antibodies as indicators of a virus' presence. Because color is subjective, according to Doctor Hari, the test results can be incorrect.

In Doctor Hari's testing technique, the results are definitive — either the gold is present or it is not.

Experimental device gives heart a rest after coronary, U-M study shows

A tiny pump implanted in a heart attack patient at The University of Michigan Medical Center took over her heart's work for three days, successfully circulating blood through her body so her heart could rest and recover.

The patient, a 33-year-old Cheboygan resident, is in good condition and her heart is beating normally after the experimental device — called the

Continued on page 10

Continued from page 9

Hemopump — was removed December 14. A team of U-M physicians implanted the pump December 11 after the patient suffered a heart attack December 5 and went into cardiogenic shock, a condition that is fatal for most patients.

The procedure was the first use of the Hemopump in Michigan. The treatment has been tried at only three other medical centers in the country, where it has been used primarily to support patients recovering from coronary artery bypass surgery.

The electronically powered device, about the size of a pencil eraser, is capable of pumping enough blood so that the heart has to do little or no work. It is thought that by allowing the heart muscle to rest, damage resulting from a heart attack may be minimized, according to John M. Nicklas, MD, a U-M cardiologist who heads the study of the Hemopump.

The Hemopump offers significant advantages over other machines, known as left ventricular assist devices, that are designed to support patients with weakened or failing hearts, Doctor Nicklas said. "While other devices have been linked to blood clots that can cause strokes, the Hemopump is not. And, unlike other assist devices, the Hemopump does not require an incision in the chest wall to place it in the heart."

The Hemopump is fitted within a catheter and threaded through the arteries into the heart from an incision in the leg, minimizing the risks of infection and anesthesia associated with chest surgery. The pump is powered by an electric motor attached to the catheter outside the body. The Hemopump uses a rotary blade spinning at 25,000 revolutions per minute to push blood through the body. It takes over the heart's work by pulling blood out of the left ventricle, the heart's pumping chamber. With no blood to pump against, the heart muscle can relax and rest.

The device will require further testing and approval by the US Food and Drug Administration before it is available for general use.

Kellogg Foundation logs record growth

The W.K. Kellogg Foundation set a new record during the 1987-1988 fiscal year, rising almost 27 percent over the previous 12-month period for funds distributed.

Expenditures amounted to $122 million — a significant increase over the previous year's total of $96.4 million and the most ever. More than $1.1 billion has been distributed since the Foundation was established in 1930.

This financial data is recorded in the 1988 Annual Report released in December at the 58th annual business meeting of the organization's Board of Trustees.

The report, which focuses on youth, also shows that $31.7 million went to projects in Michigan, including $9.5 million in the Foundation's hometown of Battle Creek. It is the highest annual expenditure in Battle Creek during the organization's 58-year history, and does not include money spent for an ongoing project to construct a new Foundation headquarters and to make other civic/public improvements in the downtown area.

Lyme disease in Michigan

As of October 18, 1988, the Michigan Department of Public Health has received reports of 29 cases of Lyme disease acquired in Michigan. These case patients reported exposure in the following counties: Bay (1); Branch (1); Clare (1); Delta (1); Dickinson (1); Gratiot (1); Iron (3); Jackson (1); Kalamazoo (1); Livingston (2); Mason (1); Mecosta (1); Menominee (8); Oakland (1); Shiawassee (4); and Washtenaw (1).

The vector of Lyme disease, *Ixodes* dammini (northern deer tick), has been found in Gogebic, Houghton, Marquette and Ontonagon Counties.

We encourage physicians to report suspected cases of Lyme disease to their local health department. If you have questions, call Harry McGee at the Michigan Department of Public Health, Division of Disease Control, (517) 335-8165.

Physicians in the News

Donald Kuiper, MD, Lansing, vice president of medical affairs and medical education at St. Lawrence Hospital, is serving a one-year term on the National Board of Medical Examiners. Doctor Kuiper is also treasurer of the board of directors of the Federation of State Medical Boards.

Thomas Schwenk, MD, Ann Arbor, is newly-named chairman of the Department of Family Practice at the University of Michigan Medical School.

Bryan Shumaker, MD, Pontiac, is new director of the Laser Center at St. Joseph Mercy Hospital, Pontiac. Doctor Shumaker will be actively involved in education, credentialing of physicians, and promotion of the Center. He is also new urology section chairman for the American Society of Laser Medicine and Surgery.

Jeffrey Band, MD, Royal Oak, director of epidemiology and chief of the Division of Infectious Diseases at William Beaumont Hospital, Royal Oak, is a new trustee of the Society of Hospital Epidemiologists of America, a national organization of physicians and doctoral-level epidemiologists.

Lawrence M. Probes, MD, a Grand Rapids psychiatrist and medical director of Kent Oaks Psychiatric Unit, recently head a delegation of physicians to the Soviet Union to represent Physicians for Social Responsibility, a national organization with over 1,000 members in Michigan. The group is dedicated to reducing the threat of nuclear war. Accompanying the delegation was Mary E. Walley, of Grand Rapids, who is a third-year medical student with the Michigan State University College of Human Medicine. She and Doctor Probes visited Armenian hospitals and talked with health care personnel near the areas stricken by the recent earthquake.

Robert Wilson, MD, Detroit, is new director of Trauma Service at Detroit Receiving Hospital, Detroit Medical Center. Doctor Wilson, who also is chief of surgery, will coordinate all clinical programs related to trauma at Detroit Receiving, which has been designated as a national Level I Trauma Center by the American College of Surgeons.

Douglas B. VanBrocklin, MD, Grand Blanc, is the new corporate medical director at General Motors. Doctor VanBrocklin served as assistant medical director at AC-Flint in 1973 and has served as regional medical director at GM's Flint Regional Medical Center since 1986. Doctor VanBrocklin is Board certified in occupational medicine and received his masters degree in public health in 1985.

E. James Potchen, MD, Lansing, chairman of the Department of Radiology, Michigan State University College of Human Medicine, is one of three authors of *Diagnostic Nuclear Medicine, Vol. 1,* published by Williams and Wilkins, Baltimore, MD. His co-authors are Yale University faculty members Alexander Gottschalk, MD, and Paul B. Hoffer, MD.

John Hickner, MD, Escanaba, medical director of the Bay de Noc Family Health Center in Escanaba, is a new member of the board of directors, Ambulatory Sentinel Practice Network (ASPN). ASPN is a group of 65 family practice offices in the US and Canada which participates in primary care research studies.

Bader J. Cassin, MD, Detroit, is the new chief medical examiner for Wayne County. Doctor Cassin is senior vice president of medical affairs, Samaritan Health Center, Detroit.

Frederick Kiechle, MD, is new chairman of clinical pathology at William Beaumont Hospital, Royal Oak.

James Heinsimer, MD, Birmingham, is new director of research at St. Joseph Mercy Hospital, Pontiac. Doctor Heinsimer will help develop, monitor, and promote research projects.

Julius Combs, MD, Southfield, chairman of the board of trustees for OmniCare Health Plan, formerly Michigan HMO, is a new member of the Board of Directors, American Medical Care and Review Association (AMCRA). AMCRA is a national trade association comprised of more than 500 alternative delivery plans.

David Rovner, MD, East Lansing, professor of medicine and chief of the division of Endocrinology and Metabolism at the Michigan State University College of Human Medicine, is the new vice president of the American Diabetes Association. Doctor Rovner is former chairman of the MSMS Annual Scientific Meeting Planning Committee.

Five physicians at the University of Michigan Medical Center are among the first in the United States to be certified in geriatrics. The U-M physicians include **James F. Peggs** and **David R. Mehr** of the Department of Family Practice. Others from the Internal Medicine Department's geriatric medicine division at Turner Geriatric Clinic are **Mark Supiano, Neal Persky,** and **Margaret Terpenning.** These physicians recently received results from an examination given by the American Board of Internal Medicine and the American Board of Family Practice.

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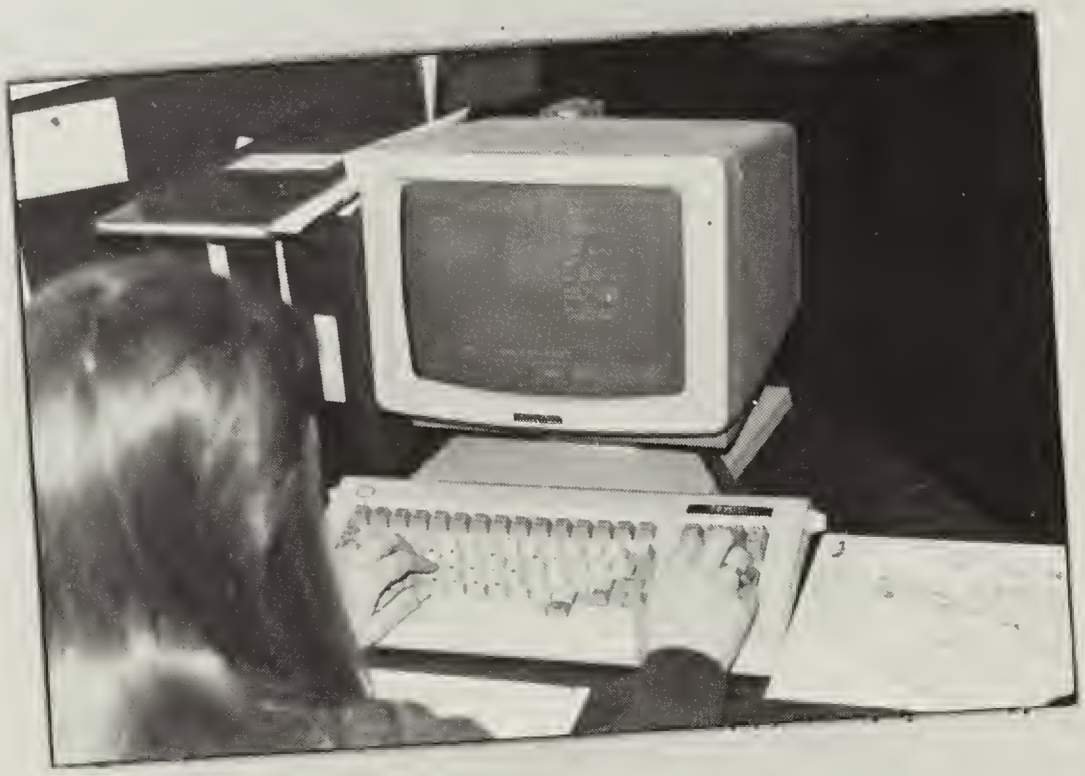

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A BIRD'S-EYE V

Cover Story

W OF THE RBRVS

By Frank B. Walker, MD

The development of a relative value scale is but one of a growing list of Medicare payment reform efforts considered by the federal government in response to mounting budgetary pressures. Others which have been considered or implemented include physician DRGs, capitation, Medicare PPOs, expenditure caps, and further restrictions on Medicare's current customary, prevailing and reasonable (CPR) system, with implementation of "inherent reasonableness" payment cuts and Maximum Allowable Actual Charges (MAACs).

The long-awaited Harvard University study was funded through a cooperative agreement with the Health Care Financing Administration. It was developed in response to a congressional mandate to the Secretary of HHS to develop a relative value scale (RVS) based on the resource costs of providing physician services. The study was begun in December 1985, with the involvement of the AMA as a subcontractor to the study. The initial report on Phase I of the study was submitted to HCFA in September 1988.

MSMS has been following the AMA's lead, allowing it to, appropriately, command organized medicine's response to this proposed program of national scope. MSMS leaders have attended special AMA meetings to discuss the RBRVS, and our state's delegates considered the RBRVS with their colleagues at the 1988 AMA Interim Meeting.

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Interested groups across the country, including the AMA and MSMS, now are analyzing the study and its ramifications. AMA policy supports an indemnity payment schedule based on an appropriate RVS as one basis for a more acceptable Medicare physician payment system. It would preserve fee-for-service medicine, while eliminating much of the complexity that has progressively replaced CPR.

The AMA has agreed that, given sufficient expansion and refinement, the Harvard RBRVS "would provide an acceptable basis for a Medicare indemnity payment system."

After considerable study and discussion, the AMA House of Delegates at its December 1988 meeting adopted Report AA, together with its 18 recommendations for implementation, should the Harvard RBRVS be adopted. Those carefully-developed recommendations are printed verbatim in this cover story for your study and understanding.

RBRVS Timetable

The AMA's meetings are part of a timetable of sessions scheduled since the RBRVS's introduction in September and prior to possible implementation of the RBRVS, which most likely could not be implemented until 1991.

That timetable also is presented in these pages to give you a better idea of the steps to be taken before this RBRVS can become a reality.

The primary message from me to you is that the Harvard proposal is just that — a proposal. Before it could become a reality, the many groups examining the proposal have the opportunity to study and comment.

MSMS will provide its own opportunities for members to learn more about the proposal and to lend your insights. We plan four informational forums during the next several months. In addition, we will serve as the convenor for discussions with the 34 recognized Michigan specialty societies.

We present this month's *Michigan Medicine* cover story as a kind of "snapshot" of the RBRVS process — to inform you of where things stand now.

We invite you to read the AMA's recommendations and familiarize yourself with the timetable for RBRVS study. And, we invite you to participate in the MSMS forums and discussions ahead.

We also pledge to continue our efforts to keep you informed. Please stay tuned.

Doctor Walker is a member of the AMA Board of Trustees and is chairman of the MSMS Board of Directors. ■

AMA RECOMMENDS THE ADOPTION OF 18 POLICIES REGARDING THE RBRVS

In order for the profession to influence the ultimate outcome of the Harvard Resource-Based Relative Value Scale and related issues, the position of Medicine must be clearly understood by all. Accordingly, the AMA Board of Trustees recommended at the AMA Interim Meeting in Dallas that the following policies be adopted:

1 That the AMA reaffirm its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using:

a. an appropriate RVS based on the resource costs of providing physician services;
b. an appropriate monetary conversion factor; and an appropriate set of conversion factor multipliers.

2 That the AMA adopt the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for Medicare indemnity payment system.

3 That the AMA work with Harvard the national medical specialty societies, the PPRC, HCFA, other interested and knowledgeable parties, and the Congress to refine and modify the Harvard RBRVS to ensure that it is technically adequate and can be implemented in a timely and minimally disruptive manner when needed revisions have been satisfactorily completed. Refinement and completion of the RBRVS will require:

- appropriate restudy of the services of specialties whose RBRVS data have significant, documented technica deficiencies;
- fundamental improvement of the measurement of practice costs and amortized specialty training costs;
- expansion of the RBRVS to more specialties and services;
- development of an extrapolation method for visits;
- revision, refinement, and expansion of the measurement of pre- and post-work;
- expansion and validation of the extrapolation methodology;
- development of expanded relative value estimates for services for which

global fees are customarily utilized as standard definitions are developed and accepted;

- appropriate action to address concerns specific to individual specialties; and
- that the AMA work to establish a mechanism to ensure that additional concerns that may be identified are communicated to and addressed by the appropriate parties and external validation is conducted by the AMA.

4 That the Association reaffirm its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing.

5 That the AMA reaffirm its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

6 That the Association promote enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

7 That the Association expand its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

8 That a Medicare indemnity payment system be implemented through a blending transition, in which physician payments would be determined in increasing proportion by an RBRVS-based indemnity payment schedule and in decreasing proportion by the current CPR payment system, or prevailing charges only. The specific transition period should be chosen in order to strike an appropriate balance between minimizing disruptions for patients and physicians while also minimizing the complexity of the process. In addition, the effects of the new system should be monitored during the transition, with corrections made as needed.

9 That the AMA reaffirm its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

10 That payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan/nonmetropolitan areas within states) based on the availability of high quality data.

11 That geographic differentials should be addressed simultaneously with specialty differentials.

12 That, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

13 That the AMA support the general principle that an RBRVS-based payment schedule should include differentials in payment for CPT codes where there are differential resource costs ("total work" and practice and training costs) across specialties. The following criteria should guide the establishment of differentials for specific services:

a. When the resource costs are substantially different across specialties; and
b. When the relevant codes are not sufficiently precise to differentiate among the content or physician work of a service across specialties, and cannot be readily refined to become so.

In addition, as few separate payment categories as possible should be established to minimize system complexity. In general, specialty differentials should be avoided except where absolutely warranted by resource cost data.

14 Specialty differentials should apply to all CPT-coded services for which a differential exists.

15 Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include but not be limited to:

- Partial completion of residency plus time in practice;
- Local peer recognition; and
- Carrier analysis of practice patterns.

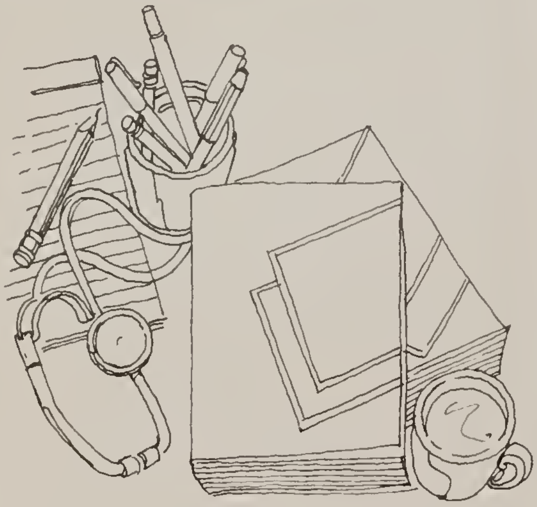
A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

16 That the Association strongly oppose any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

17 That whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience, and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

18 That the Association strongly oppose implementation of Medicare expenditure targets, which will lead to the rationing of care for Medicare beneficiaries, and instead support constructive approaches to enhancing quality and appropriateness of care. ■

Medicare Physician Payment And The RBRVS: Key Milestones



- January 18-19, 1989 – Physician Payment Review Commission (PPRC) meeting.
- January 1989 – New Administration.
- February 8, 1989: Second PPRC hearing on Harvard RBRVS.
- February 9-10, 1989: PPRC meeting.
- March 9-10, 1989: PPRC meeting.
- April 1989: PPRC report to Congress – with RVS recommendations.
- April 6-7, 1989: PPRC meeting.
- June 1-2, 1989: PPRC meeting.
- June 1989: House of Delegates meeting – Board Report on RVS Status.
- July 1, 1989: Secretary of Health and Human Services (HHS) report to Congress on an RVS/fee schedule for implementation on January 1, 1990.
- October 1, 1989: HHS report on RVS expansion to 15 additional specialties due.
- November 9-10, 1989: PPRC meeting.
- December 1989: House of Delegates meeting.
- June 1990: House of Delegates meeting.
- December 1990: House of Delegates meeting.
- January 1, 1991: Estimate of earliest possible Medicare RVS/fee schedule implementation.

Federal

Significant Victories Won On A Number Of Key Issues

Editor's note: *The following inf mation is reprinted from the Octob 1988 issue of* "Talking Points," *monthly newsletter published by t American Medical Association legislative, regulatory and politic news.*

TIVE ROUNDUP

AMA can celebrate significant victories on a number of key issues that were before Congress during the final days of the Reagan Administration:

Clinical labs. Foremost among these victories was passage of H.R. 5471. The bill assures provision of quality lab services without imposing burdensome requirements on physicians and patients by fully recognizing and encouraging private accreditation activities to establish appropriate standards, mandating different personnel standards based on laboratory practice setting and test categories, granting certification for laboratories that have fulfilled private accreditation standards and waiving certification for labs involved in simple tests, providing laboratories with an expeditious method of updating their original certification applications in order to recognize new as well as changing and expanding technologies, establishing feasible and reasonable standards that are commensurate with the service involved, and allowing for an appropriate phase-in of these standards. Deleted from the bill were required direct billing, prohibition on self-referral and mandated inspection prior to certification provisions. Also defeated – a provision that would have amounted to a potential denial of due process for labs failing proficiency tests.

AIDS. H.R. 5142 passed the full House in mid-September under a "modified, open rule" that narrowed the number of potentially damaging amendments that would have made the bill a vehicle for the far-right agenda. The progressive, medically-based position of the AMA, widely credited with the lop-sided defeat of crippling amendments, calls for mandated reporting to state public health officers and required mandatory HIV testing for hospital admissions. AMA also strongly supported and helped shepherd through passage Sen. Edward Kennedy's (D-MA) AIDS research and education legislation, S. 1220.

Kennedy and Waxman had hoped to combine the two bills and pass them quickly, given the wide margins of support on previous votes. Under threat of filibuster from Senate conservatives, counseling and testing provisions had to be dropped. The pared-down legislation ultimately passed as part of a larger, eight-part public health package, S. 2889. Funds for anonymous testing were retained along with research, education and Rowland-style AIDS commission.

UBIT. Persistent rumors that oversight subcommittee Chairman Jack Pickle (D-TX) would try to forward his draft UBIT reform to the full House Ways and Means Committee were finally put to rest. Pickle, meeting with his subcommittee shortly before adjournment, was forced to acknowledge that his package could not be moved. As written, the draft recommendations would have drastically harmed non-profit organizations with provisions ranging from aggregation of income by controlled subsidiaries to increased royalty taxes to truncated advertising expense deductions.

Tobacco. H.R. 5113, Tom Luken's (D-OH) omnibus anti-smoking bill did not reach markup this Congress despite attempts to force consideration by his subcommittee on transportation, tourism and hazardous materials (House Energy and Commerce Committee). The landmark bill would have incorporated the AMA-endorsed H.R. 1272, Mike Synar's (D-OK) tobacco ad ban measure. Further, it would have banned the sale of tobacco in vending machines, required an "addictive" warning label on cigarettes, and authorized the FTC to test smoke for various contaminants.

HMO/dual choice. The AMA was successful in modifying a provision of the 1973 HMO Act which mandates that employers who provide health insurance must offer HMO coverage. The so-called dual-choice requirement will be completely eliminated after seven years, although employers still offering HMO plans will be required to make equal contributions to their employees who choose the HMO option. While not the full and immediate relief organized medicine had pushed for, the HMO Act modification represents a significant victory for traditional fee-for-service indemnity plans, since Sen. Kennedy had vowed never to give in to any such change.

Physician dispensing. Legislation introduced by Rep. Ron Wyden (D-OR) to severely restrict physician dispensing died in the House after being ordered reported by the full Energy and Commerce Committee. Wyden failed to get the backing of Chairman Dingell who wanted to wait until a comparable Senate bill was introduced, something the AMA prevented from happening.

Unnecessary services. As a result of AMA and Federation lobbying, HCFA ordered the South Carolina Medicare carrier to issue letters of apology to physicians and beneficiaries who earlier had received "unnecessary services" letters. In addition, carriers must also release UR/medical necessity written policies. The AMA met with Dr. Bill Roper, HCFA administrator, to outline physicians' continuing concerns with the implementation of the unnecessary services authority and lobbied members of Congress for a GAO study of HCFA's implementation practices. AMA received a commitment from HCFA to improve data collection on the success and failure rates for specific utilization review screens. This information, available this month, may provide strong evidence to support modification of medical necessity screens.

Patient dumping. HCFA unleashed a storm of protest when it released its "patient dumping" letter, threatening hospitals with severe penalties for failing to comply with various anti-dumping laws. AMA held several meetings with Tom Morford, HSQB, and pressed for a coalition effort by AHA, AMA, AARP and HCFA to study the problems, ease enforcement, increase awareness of the requirements and prevent physician flight and emergency room closures. AMA will continue to intervene informally on behalf of physicians caught up in termination proceedings to obtain accurate information and advice from HCFA and aid in structuring a rational response to termination proceedings. ■

State

A Record Number Of Bills Passed In 1987-88

By Mitchell A. Rinek, MD
Chairman, MSMS Committee on State Legislation and Regulations

The Michigan Legislature passed a record number of bills in the 1987-1988 session which just adjourned in December, 1988. And, more than twenty-five percent of those bills were approved in the last two-day flourish of the Legislature. While it would be impossible to describe all the bills eventually signed into law, there are a number of laws that Michigan physicians should be aware of.

This article will attempt to briefly describe the major new laws that affect Michigan physicians. If anyone needs more detail, they should either refer to the MSMS Government Relations Agenda (GRA SHEET) or contact the MSMS Department of Government Relations.

AIDS Legislation

Issues surrounding the AIDS epidemic attracted considerable attention this legislative session. Education, testing and prevention measures were addressed through nine new laws, which include:

Public Act # 185 of 1987, which requires information on all dangerous communicable diseases, including AIDS, to be taught in every public school.

Public Act #258 of 1987, which establishes the Michigan Health Initiative which provides for free pre- and post-test counseling throughout the state, creates the Risk Reduction and AIDS Policy Commission, and the development of an AIDS Educational Module with the federal government to be distributed to every household in Michigan. The law also provides for grants for health promotion programs at worksites. The fund for this program is financed through the four percent sales and use tax on computer software.

Public Act #471 of 1988, which provides that those arrested for crimes where transmission of HIV is possible, i.e. prostitution, criminal sexual misconduct, and IV drug abuse, be recommended by the judge or magistrate to receive AIDS education and counseling and educational material about HIV testing and victims of the crimes will be notified of the results.

Public Act #510 of 1988, which requires all incoming prisoners to be given an HIV test, requires that all who test positive receive counseling and education on the HIV virus, allows segregation for prisoners who are HIV positive under certain circumstances, provides AIDS education for all employees upon request, and provides employee testing for HIV free of charge upon request.

Public Act #487 of 1988, which requires physicians and health facilities to perform HIV tests for body organs and/or fluids when providing artificial insemination, blood transfusion, organ transplant services in order to limit the potential for the spread of the HIV infection.

Public Act #488 of 1988, which requires written informed consent prior to HIV testing and requires test subjects to receive information about the HIV virus and the availability of anonymous testing. The bill also stipulates to whom and under what conditions the HIV test results may be disclosed and provides penalties for unauthorized disclosures.

Public Act #489 of 1988, which establishes a procedure for all positive HIV test results to be reported to local and state health departments. It is a choice of the individual as to whether the test is on an anonymous or confidential basis. There is also a procedure established which encourages the infected person to contact known partners. Local health departments can be involved in partner notification if the infected person needs assistance.

Public Act #490 of 1988, which creates new and revised sections of the Public Health Code defining individuals who are health threats to others, and provides procedures for dealing with individuals infected with the HIV virus who repeatedly and willfully place others at risk to contract the disease. The procedure includes a warning notice, a review panel, and as a final action, probate court involvement.

Public Act #491 of 1988, which establishes health department authority for dealing with communicable and serious communicable diseases, and defines HIV infection as a serious communicable disease. It also requires that all persons applying for marriage licenses shall receive from the county clerk information regarding HIV transmission, as well as a list of locations where HIV testing and counseling services are available. Physicians and /or local health departments shall counsel a couple applying for a marriage license regarding the transmission and prevention of venereal disease and HIV infection. They also must offer tests for both venereal disease and HIV infection.

Certificate of Need

After two years, the Michigan Legislature finally approved a five-bill package designed to reform the state's Certificate of Need (CON) and health planning statutes. The new laws became effective October 1, 1988.

The law established two thresholds for requiring a CON – $750,000 for projects involving a clinical service area, and $1.5 million for projects involving a non-clinical area. A CON is required to acquire certain medical equipment or to initiate certain services. Covered medical equipment and services are defined by law, and include MRI, lithotripters, fixed or mobile CT scanners, inpatient or outpatient surgical facilities, PET scanners, air ambulances, cardiac services, extrarenal organ transplantation, special radiological procedure rooms, specialized radiation therapy services and open heart surgery.

The Committee was quite pleased that all principles for CON reform adopted by MSMS were incorporated in the package. Those included: an increase in the capital expenditure threshold; provisions requiring expert input into CON review criteria; review and revision of all existing CON review criteria; and provisions enabling quality assurance to be part of the CON review process.

Controlled Substances

The legislature adopted a major anticrime package in 1988. A great portion of that package was aimed at the growing problem of drugs and drug diversion in Michigan. Those new laws include:

Public Act #28 of 1988, which requires physicians to write controlled prescriptions to indicate the quantity in both written and numerical terms.

Public Act #245 of 1988, which requires an annual inventory of Schedule II controlled substances by controlled substance licensees.

Public Act #10 of 1988, which limits the purchase of Schedule I and II controlled substances to licensed practitioners.

Public Acts #60-61 of 1988, which created the Michigan Triplicate Prescription Law, requiring triplicate prescription forms to be used for all Schedule II controlled substances. The package also increased controlled substance license fees.

Public Act #139 of 1988, which prohibits the possession, use, delivery, and manufacture of controlled substances and drug paraphernalia under certain circumstances, and prohibits the advertising of drug paraphernalia.

Public Act #29 of 1988, which prohibits licensing any person under the Public Health Code for engaging or having a financial interest in a business with a controlled substance license for a period of five years after a controlled substance related drug conviction.

Other Laws

Public Act #35 of 1987, which requires physicians to make an immediate oral report in cases of elderly abuse to the County Social Services Department.

Public Act #236 of 1988, which creates a statewide registry of birth defects in the Department of Public Health.

Public Act #213 of 1987, which allows physical therapists to evaluate patients without a physician's prescription.

Public Act #122 of 1988, which creates a registry for reporting closed head injuries within the Public Health Department.

Public Act# 63 of 1988, which defines the donation of human tissues as a service instead of a sale.

There were a number of bills also signed into law dealing with Alzheimers' Disease, the single business tax, prescription drugs for senior citizens, health maintenance organizations, PKU tests for newborn children, surrogate parenting, transfer of health licenses from out of state, enrolling minors in drug treatment programs, and other related issues.

As always, there are a number of bills that do not get approved by the legislature before it adjourns. Among those were bills to amend the chiropractic scope of practice, require mandatory assignment of Medicare claims, allow living wills, allow countersuits of attorneys who file frivolous lawsuits, require seat belt usage by children aged fifteen and under, require fetal alcohol syndrome pamphlets to be distributed by physicians, protect pension plan assets from bankruptcy proceedings, limit physician delegation, create the State Medical Liability Trust, regulate medical waste disposal, clarify the issue of physician ownership of clinical laboratories, reform the Medical Malpractice Reform Act of 1986, provide direct nurse reimbursement, require mandatory arbitration in health insurance, require physicians to carry liability insurance as a condition of licensure, increase all terrain vehicle (ATV) safety, and others.

Most of these bills will be reintroduced in 1989, especially the bills to protect pension plans, further reform the liability laws, increase ATV safety, improve the child restraint law, regulate medical waste disposal, allow countersuits in malpractice cases, mandate arbitration as an option in health care insurance, provide for living wills, require mandatory insurance and require mandatory assignment of Medicare reimbursement. ■

Governor Blanchard

Asks For Help In Lowering State's Health Costs

As excerpted from the governor's address on health care costs delivered recently in Lansing.

Working together in a bipartisan fashion, we can make tremendous strides in our state, whether in our finances, our educational system, our jobs and economic development strategy, or any other area.

So I have asked you to come here today because I need your help, and I need to work with you to develop a much better way of containing health care costs while making sure that Michigan remains one of the best places in the world for health care, as it is now.

The reality is that costs are excessive in Michigan and they are likely to get worse, given the aging baby boom generation, new technologies that all of you are aware of, the uncalculated effects of AIDS and other substance abuse issues.

When I pull my advisors together, they say you have about three options: One, we can live with high costs. But we do not want to...It is just not an acceptable option.

Another option is to embark on a new wave of regulation, which has been tried in other states but which we view as far from the ideal option.

The third option, of course, which we think is the better way and the only one which makes sense in the long run, is for all of us to learn to cooperate better together. We must work together to control costs through the concerted efforts of the individuals and organizations with the biggest stake in the outcome — and that is all of you. That is me. All of us working together.

State's Health Care Costs Among Region's Highest

I ask your support for and commitment to a more cooperative approach to managing health care costs. Our goal will be as follows: Michigan's per capita health care costs should be below the average for the Great Lakes Region by 1993 without sacrificing the quality care that we have in this great state. I am told that our health care costs are the third highest in the region, but they are only one percent above the average. So we think it is realistic in five years to see our costs drop below the average. And we believe that can be done without a radical change in the way health care is delivered.

But I think it will require us to do things better than the competition. Let me describe what my advisors suggest should be the state government's role, some components of which are already under way.

First, we will continue to follow a general strategy of improving access to health care, whether through Medicaid or private insurance.

We are willing to take a fresh look at the whole issue of medical malpractice, from an insurance fund, trust fund type of arrangement to other methods of dealing with medical malpractice insurance costs that face providers and patients.

We will thoroughly analyze the extent to which state government practices drive costs upward throughout the entire system.

We are going to continue to attack the demand side of health care as well, through programs to promote wellness and to reduce chronic disease.

We are also talking about programs to promote wellness in local communities through a unique partnership between what we call Community Growth Alliances, which are regional economic development organizations around the state, and local health departments.

We are doing everything we can to continue to provide employers with the tools they need to make informed health care purchases. As you know, with the assistance from state and private groups, the Michigan Health Data Corporation is developing a high-quality data base that should give health care purchasers an unprecedented ability to recognize and obtain high-quality, cost-effective care for their employees.

Private Sector Can Help In A Variety Of Ways

Blue Cross/Blue Shield is an incredible organization with a huge number of subscribers. We need to help them and they need to succeed in their efforts to control costs.

Providers, we want you to work with us and the legislature to make sure we have a thoughtful, positive, and consistent approach to medical malpractice.

We are going to need to have private employers show continued leadership in promoting workplace wellness and in helping prevent substance abuse.

As they have in the recent past, our friends in the labor community need to show flexibility in their benefit demands without sacrificing the care of their membership.

Employers who have purchased health care will have to be vigorous in pursuing good value as well. We have noticed incredible variations within our own state in the cost of health care between one company and another, one community and another. This tells us that local efforts can make a big difference.

Now, I have only scratched the surface on this issue. Almost everyone here knows more about it than I do. But I know how to put together a winning team. We have done it with economic development. We have done it with financial recovery and with other areas. We will need to do it with health care costs.

In the next few weeks, we are going to appoint a working group — a small group of providers, purchasers, insurers, consumers, and state government officials — to put together a comprehensive plan for containing costs in the 1990s. In fact, I would like by next July to have that task force recommend steps to me that should be taken immediately to keep a lid on costs.

The stakes are very high and you know that, as I said, much better than I do. And I absolutely believe that an effective plan will require sacrifice by all of us. But if we are willing to take risks, and think long term, we can do a lot of good. ■

THEODORE W. KILAR, M.D.
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INVESTMENT MANAGEMENT
ANALYST

★*CERTIFIED*
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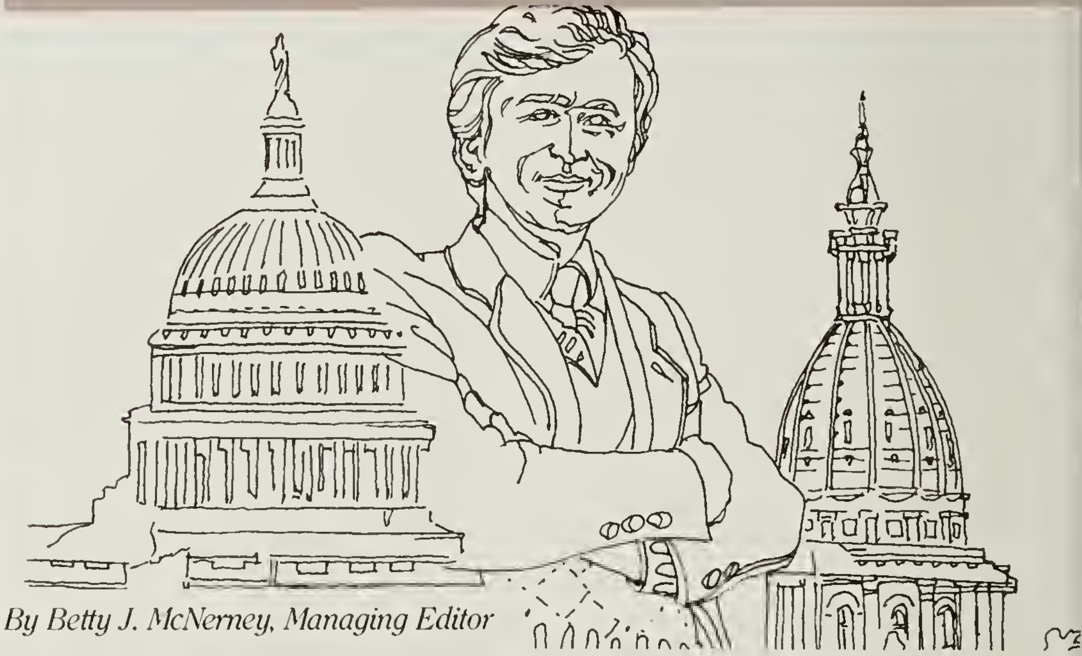

By Betty J. McNerney, Managing Editor

Peter A. Duhamel, MD
MDPAC Chairman

It is hard for the individual physician to make an impact on an election outside of his/her own legislative district. The Michigan Doctors Political Action Committee (MDPAC) unites the doctors of Michigan into one large, potent force, creating a definite expression of the physician's point of view in various elections.

So says Peter A. Duhamel, MD, MDPAC chairman.

"On the local level, physicians can donate funds to their local legislator's campaign, donate time, or donate their office for use as a phone bank," Doctor Duhamel explains. "But, for a physician to have any impact outside of his/her district is very difficult. That's where MDPAC becomes a potent political force."

How MDPAC works

MDPAC operates independently of the Michigan State Medical Society.

The main purpose of MDPAC is to collect and pool political contributions from a large number of concerned individuals (i.e. physicians and their spouses). MDPAC channels those donations to key races to support candidates more sympathetic to the physicians' point of view, or those in very closely contested seats who would appreciate the funds.

How MDPAC funds are allocated is decided by the MDPAC Board of Directors, which has 30 members. Eighteen represent each of Michigan's 18 congressional districts, eight serve as at-large members, two represent the MSMS Board of Directors and two represent the MSMS Auxiliary. The Board ultimately is responsible for determining the amount of money MDPAC disperses to certain candidates, which candidates MDPAC supports, and other activities to support. Each member of the Board serves a two-year term.

Three classes of membership

MDPAC has three classes of membership – family – $225, sustaining – $150, and regular – $50. Family membership is a new class which allows a physician's spouse – if already an MSMS Auxiliary member – to join MDPAC at half the price of a sustaining membership, and qualifies both as MDPAC/AMPAC sustainers.

"We feel this new membership class is very important," says Doctor Duhamel. "All spouses of Board members are invited to attend MDPAC Board meetings, and sometimes we have 40 to 50 people at the meetings. Spouses don't have a vote, but they certainly make their opinions very well known. It is good to have the views of the spouses regarding certain candidates."

Continued on page 26

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Peter A. Duhamel, MD, Chairman, MDPAC

Copies of MDPAC and AMPAC reports are filed with the Federal Election Commission, Washington, D.C. If your practice is incorporated, MDPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions to MDPAC are not tax deductible for Federal Income Tax purposes.

Continued from page 24

How candidates are chosen

There are two ways MDPAC offers its support to political candidates, Doctor Duhamel explains. "First of all, there may be a particular candidate to whom MDPAC feels very closely aligned. There have been a couple of such candidates in recent years. One was Senator John 'Joe' Schwarz, MD (R-Battle Creek). We felt very strongly about his candidacy and thus gave him the maximum contribution for both his primary and general election races. Another candidate in the past two elections was Nancy Crandall (R-Muskegon), who has been very active in the organized medicine process. She is a past president of the MSMS Auxiliary and her husband Donald K. Crandall, MD, is a past president of MSMS. We decided to support her in both of her elections...two years ago and then this year. We also support candidates we believe have a very strong sympathy for the plight of organized medicine.

"The second way is that occasionally we have candidates who approach us for support – people we may not have supported before or people who are new candidates. There are a number of strategies we utilize to help us in choosing to support a given candidate. We primarily depend upon the local physicians...how they feel about this particular person. Frequently, we arrange candidate interviews on the local scene where several physicians, including some MDPAC Board members, interview the candidate individually. After both candidates have been dismissed, the physicians determine a consensus opinion as to whom MDPAC should support, and then they bring it before the MDPAC Board for discussion.

Usually, the MDPAC Board will support the decisions made by the local group of physicians. We've had some races where one candidate is supported by one group of physicians and the opposite candidate is supported by another group of physicians. Sometimes in those cases we find it more prudent to just stay out of the election."

How influential is MDPAC?

On the whole, MDPAC is quite influential, says Doctor Duhamel. "In this past campaign we supported a number of challengers who were running against established incumbents. Several of these challengers were successful, with MDPAC's help, in ousting the incumbents.

"A great example is the 94th House District in the Grand Rapids area in 1986. Representative Ken Sikkema, the current representative from that district, ousted long-term incumbent Jelt Sietsema, who was vocal in his opposition to Michigan physicians. MDPAC, on the advice of local physicians, strongly opposed Sietsema who, by the way, had strong business support. MDPAC was successful in helping Representative Sikkema get elected."

Always a concern to the MDPAC Board is what might happen in a situation where MDPAC supports a challenger and the incumbent wins.

"The incumbent is going to know that you supported the challenger and be very unhappy with you," he says. "The incumbent, perhaps, will remember this when future legislation rolls around and will say, 'Well, the doctors don't like me, they supported my opponent.'"

However, Doctor Duhamel notes, "We really haven't made any dangerous enemies or made any enemies more dangerous than they were before.

"In fact, we feel in some of the cases we have gotten the attention of the legislator in question...that we didn't like what the legislator was doing and that we were supporting his/her opponent.

"In a few cases, it has actually turned the legislator around. They start to communicate with us more. We've had people we didn't support who now are our friends, or at least are friendlier than they were before."

Buying votes a no-no

Doctor Duhamel says it's hard to determine MDPAC's influence in dollars and cents because, "We do not buy a legislator's vote. This is probably the most important thing I want to say.

"People have the wrong idea about the PAC – that we are out there just to spend a lot of money and to buy votes. First, any legislator whose vote you could buy on a particular issue is probably not a very good legislator. We (MDPAC) support the legislators we know have been supportive of our views. We will not buy their vote on a particular issue or bill. But when state House and Senate races are now costing more than $100,000, it's only normal to rely on PAC support."

MDPAC looks to lobbyists to influence a legislator's vote. It's important to note, says Doctor Duhamel, that the lobbyists work for the Michigan State Medical Society and not for MDPAC.

"The PAC is not the medical society," he says. "It is independently funded and operated. MDPAC is a separate organization."

A look at the liability issue

Membership in MDPAC has dropped off slightly since the passage of the Tort Reform Act of 1986, but Doctor Duhamel remains optimistic.

"I think we've realized more success from that than anyone really expected at the time. We've seen portions of the legislation that nobody paid much attention to at the time that appear to be fairly effective in improving the liability situation. In fact, there are a number of states trying to duplicate several portions of that law."

As for the members who left MDPAC, Doctor Duhamel says, "All we can do is try to win them back and tell them that the PAC is effective and that MDPAC would appreciate their participation and contributions to further our efforts in the political arena."

Key contact program plays an important role

Getting favorable legislation passed – particularly regarding professional liability – depends in great part upon having physicians who serve as "key contacts." These are individuals who are willing to get to know their local legislators on a personal level and to communicate with them at a moment's notice.

"In each legislative district there should be at least one physician who knows that legislator personally. We would prefer that be somebody who has actively campaigned for the legislator in past elections.

At present, a number of MDPAC members, particularly MDPAC Board members, serve as key contacts for the Society."

Plans for the coming year

In the coming year, according to Doctor Duhamel, MDPAC will continue to collect contributions – even though it's an off-year for elections – and will work to build up its war chest for 1990. In the meantime, says Doctor Duhamel, "We will use some of our educational dollars to build bridges with the people who have disagreed with us in the past...not to lobby about any particular issue, just to get to know them better, to get them to know us and our point of view better, and to try to generate more goodwill and understanding. Our goal is to develop a professional respect between legislators and physicians." ■

For more information on MDPAC, or about how to join MDPAC, contact Dan Farhat at MSMS.

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Maternal Death

As A Result Of Anesthesia -

The Michigan Experience

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Since 1950, every maternal death occurring in Michigan has been reviewed by a subcommittee of the MSMS Committee on Maternal and Perinatal Health to determine the cause of death and to identify possible avoidable factors. Known as the Michigan Maternal Mortality Study, this review represents a cooperative effort between the Michigan State Medical Society, the Michigan Department of Public Health, and the chairmen of the departments of obstetrics and gynecology of our state's three medical schools.

The subcommittee bases its determination of information collected on-site by a Regional Visiting Obstetrician. Using the AMA's Guide for Maternal Death Studies, each maternal death is classified as either a direct (due to true obstetric causes), indirect (due to nonobstetric medical problems), non-related (e.g. car accident), or undetermined death.

The results of the review for the period from 1950 to 1971 were published in 1977 (Am J Public Health 67:821, 1977). While the report made no mention of deaths attributable to anesthesia, the continued review of all maternal deaths since 1972 did identify those cases in whom anesthesia was either the primary cause or a contributory factor. It was found that during the period from 1972 through 1984, 15 maternal deaths were primarily due to anesthesia, accounting for 6.9 percent of direct maternal deaths, or 0.82 per 100,000 live-births. Anesthesia was a contributory factor in four deaths. No death related to anesthesia was recorded during the last two years of the study (1983 and 1984) and anesthesia-related mortality had reached a low plateau during the preceding four years.

A rate of 6.9 percent compares well to results of a study carried out in England and Wales which, due to its exemplary reporting and review methodology, is considered by many a benchmark in maternal mortality reviews. Results for the most recent triennium (1979-1981) showed a rate of 12.6 percent. There are only very few recent studies in the United States, all of which are regional in scope and showing results similar to the English and Welsh study.

Study Reveals Three Principal Findings

Aside of the aforementioned decline in anesthesia-related maternal death rate, our study revealed three principal findings:

- ■ Failure to secure a patent airway emerged as the predominant cause of anesthesia-related maternal death in recent years (since 1980);
- ■ Risk factors in the form of obesity, hypertension, and the emergent nature of the procedure, singularly or in combination, were present in all but one patient;
- ■ Thirteen of the 15 deaths occurred in black patients.

The failure to establish and maintain airway patency during anesthesia is usually related to the inability to successfully intubate the trachea ("failed intubation"). Because of the pregnancy-induced increase in oxygen consumption and decrease in functional residual capacity, pregnant patients become hypoxic much more quickly than do surgical patients, if intubation is not carried out expeditiously. Regional anesthesia will not only circumvent difficulties in intubation, but it should be considered whenever a major anesthetic becomes necessary, since fetal outcome has been shown to be better following spinal or epidural anesthesia when compared to general anesthesia. If regional anesthesia is contraindicated and intubation can be expected to be difficult, awake intubation either under direct vision or by means of fiberoptic laryngoscopy should be considered. Proper placement of the endotracheal tube should be ascertained by using a capnometer to measure end-tidal carbon dioxide. If CO2 in the exhaled gas mixture is within a normal range, the endotracheal tube is properly positioned. Universal application of this monitoring modality could materially reduce the incidence of unrecognized esophageal intubation. Also, obstetricians and anesthesiologists should agree on a detailed plan on how to proceed when airway difficulties arise to enable them to effectively deal with such contingencies ("failed intubation drill").

During the study period, five deaths were associated with the use of regional anesthesia. No death was recorded after 1978. This decline reflects world-wide trends, and must be considered the result of improvements in anesthesia practice (preloading with intravenous fluids prior to administering regional anesthesia and left uterine displacement if the patient must be placed in a supine position). Safety also has been improved by the recognition that pregnancy reduces drug requirements for both spinal and epidural anesthesia.

We have found only two cases of pulmonary aspiration. This is surprising because this complication has accounted for about half of all anesthesia-related mortalities in the past. However, the greater use of antacids, routine insertion of an endotracheal tube when general anesthesia is indicated, and the use of cricoid compression during intubation have contributed in recent years to reduce mortality and morbidity associated with aspiration.

Three Risk Factors

Our study identified three risk factors — namely obesity, hypertension, and the emergent nature of the procedure. Present in 12 to 15 patients who died, obesity often makes both endotracheal intubation and regional anesthesia very difficult. Some changes resulting from obesity accentuate similar ones caused by pregnancy. One example of such a combined effect is the greater spread of local anesthetics injected into the subarachnoid or epidural space than the spread caused by either condition alone. Other examples are changes in respiratory function of similar nature which combine to render the obese parturient very prone to quickly become hypoxic when airway difficulties arise.

In 12 patients, 80 percent anesthesia was administered under emergency conditions. This finding highlights the need for anesthesia personnel to acquaint themselves with patients when they are still in the labor room and to closely communicate and coordinate actions with obstetricians.

Hypertension was a risk factor in eight of 15 patients. Due to a reduced blood volume, hypertensive patients receiving a regional anesthetic frequently incur a marked drop in blood pressure. Careful preoperative volume replacement is very essential. Laryngoscopy and intubation during general anesthesia often are associated with severe increases in blood pressure which can be dampened by the use of antihypertensive drugs (hydralazine, nitroglycerin, trimethaphan).

The study revealed that of the 15 patients who died, 13 were black. Thus, during the reporting period a black patient's exposure to the risk of dying from causes related to anesthesia was 30 times greater than that of a white patient. Clearly, such marked variance cannot solely be explained on the basis of a higher incidence of hypertensive disease and obesity in black pregnant women and a reduced access to or use of prenatal care. It may be related, at least in part, to the greater difficulty in recognizing cyanosis in patients with skin of darker complexion. Before pulse oximetry became available a few years ago, cyanosis was often the first clinical sign that alerted the anesthesia provider to impending life-threatening hypoxemia in patients whose respiratory exchange became severely compromised. Hopefully, the universal application of this new monitoring modality will reduce the incidence of anesthesia-related death.

Immediate Postoperative Care Is Critically Important

The care provided to patients during the immediate postoperative period both in the obstetric postanesthesia care unit (PACU) and on the floor is of critical importance. The most recent English and Welsh study labeled postoperative care as substandard in almost one third of deaths. Patients at times return to the floor markedly sedated and require continued close surveillance. Obstetric PACU's are often understaffed during peaks in obstetric activity. Also, these units usually are staffed by perinatal nurses as part of their overall perinatal care responsibilities. They cannot be expected to possess the same level of experience and skill as do nurses permanently assigned to surgical PACUs. Except for one center where nurses are assigned solely to its combined obstetric PACU and maternal special care unit, such staffing pattern is typical of Michigan's 14 perinatal centers (defined as having an active obstetric service and a neonatal ICU). However, some options do exist in some centers when higher level of care during the immediate postoperative period is required, such as transfer to the ICU or the surgical PACU, or the summoning to the unit of surgical PACU nurses.

One patient in our review received epidural analgesia during labor and was found in an unresponsive state. She later died of anoxic encephalopathy. When during the course of epidural analgesia, anesthesia personnel cannot remain in the labor room, there must be close observation by perinatal nurses who have both the training to recognize complications of epidural blocks and the ability to initiate treatment.

This and other studies emphasize the importance of taking specific steps to reduce the risk of anesthesia in parturients. These include the use of regional anesthesia whenever indicated; meticulous monitoring that should encompass, when appropriate, pulse oximetry and capnometry; the use of antacids; the development of a comprehensive plan to deal with airway problems, and assurance of appropriate levels of postoperative care. As voiced by leaders in the field of obstetric anesthesia, an important factor in enhancing the safety of anesthesia during childbirth is an improvement in around-the-clock coverage by anesthesiologists who have both the interest and experience in the care of parturients. Based on a study published in 1986, such coverage existed at the time of survey in only 49 percent of the nation's obstetric units with greater than 1,500 deliveries per annum. In a survey of Michigan's perinatal centers completed in December 1988, in-house 24-hour coverage by anesthesiologists is available in 11 of 14 centers (79 percent).

Results of this study recently have been published in greater detail (Am J Obstet Gynecol 159: 187-93, 1988). The report was dedicated to the memory of Lee B. Stevenson, MD, a co-author of the paper who has been instrumental over the years in carrying on the Michigan Maternal Mortality Study and whose recent untimely death has been a great loss to our profession. ■

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sland Conference Promotes Healthy Living

By Naomi Harris

Health promotion is a virus which is spreading in Michigan's schools. Educators, school administrators, students and support staff are being infected; but, they are welcoming this new bug!

Last spring, approximately 70 local school districts representing all areas of Michigan organized a team to attend the Third Annual Island Conference for School Workplace Wellness held on Mackinac Island. The Mission Point Hotel and Conference Center was the site for the week-long event designed to help school districts plan and implement workplace wellness programs.

The Island Conference, which MSMS has been instrumental in developing, has been the catalyst for many school-based wellness programs in the past three years.

In the fall of 1985, the Gratiot-Isabella Intermediate School District, located in Ithaca, began looking at school-based wellness programs in Michigan. Their first step was to do a formal needs assessment of all their employees regarding: (1) health behavior; (2) health knowledge; and (3) health attitudes. The results of the survey revealed the following:

- These employees had health concerns similar to national reports.
- These employees were interested in knowing more about their own personal health status.
- These employees were interested in becoming involved with a workplace wellness program to improve their health status.

History

In June of 1985, the Gratiot-Isabella Intermediate School District sent a team to the first Island Conference. The team included a board member, senior administrator, a principal, a paraprofessional, a clerical worker and the Intermediate School District health educator. Together, they attended workshops and met daily to organize and plan for the implementation of a schoolsite wellness program. Meetings occurred over the following summer and fall. Finally, a proposal was written and presented to their local board of education.

The Program

The program identified several activities for the 1987-88 school year. They were individual health risk assessment and small group counseling, laboratory biomedical testing and health education sessions on topics such as nutrition, exercise and weight control. These services were provided by Central Michigan University's Health Education/Health Science Department.

Over half of the employees participated and the Board of Education approved the program with a shared cost incentive.

Employees began walking programs, aerobics and other health-related activities. The school year ended with a beginning of health awareness!

Currently, the program has expanded to include not only the above activities, but also an employee wellness newsletter and calendar of events. New topics for inservice are planned and additional exercise activities are available.

Evaluation

After the first year a questionnaire was distributed to all participants asking for their response to the wellness program, specifically to their own behavior change. The responses were very positive to the program and showed promise in aiding colleagues in their desire to change unhealthy behaviors.

Summary

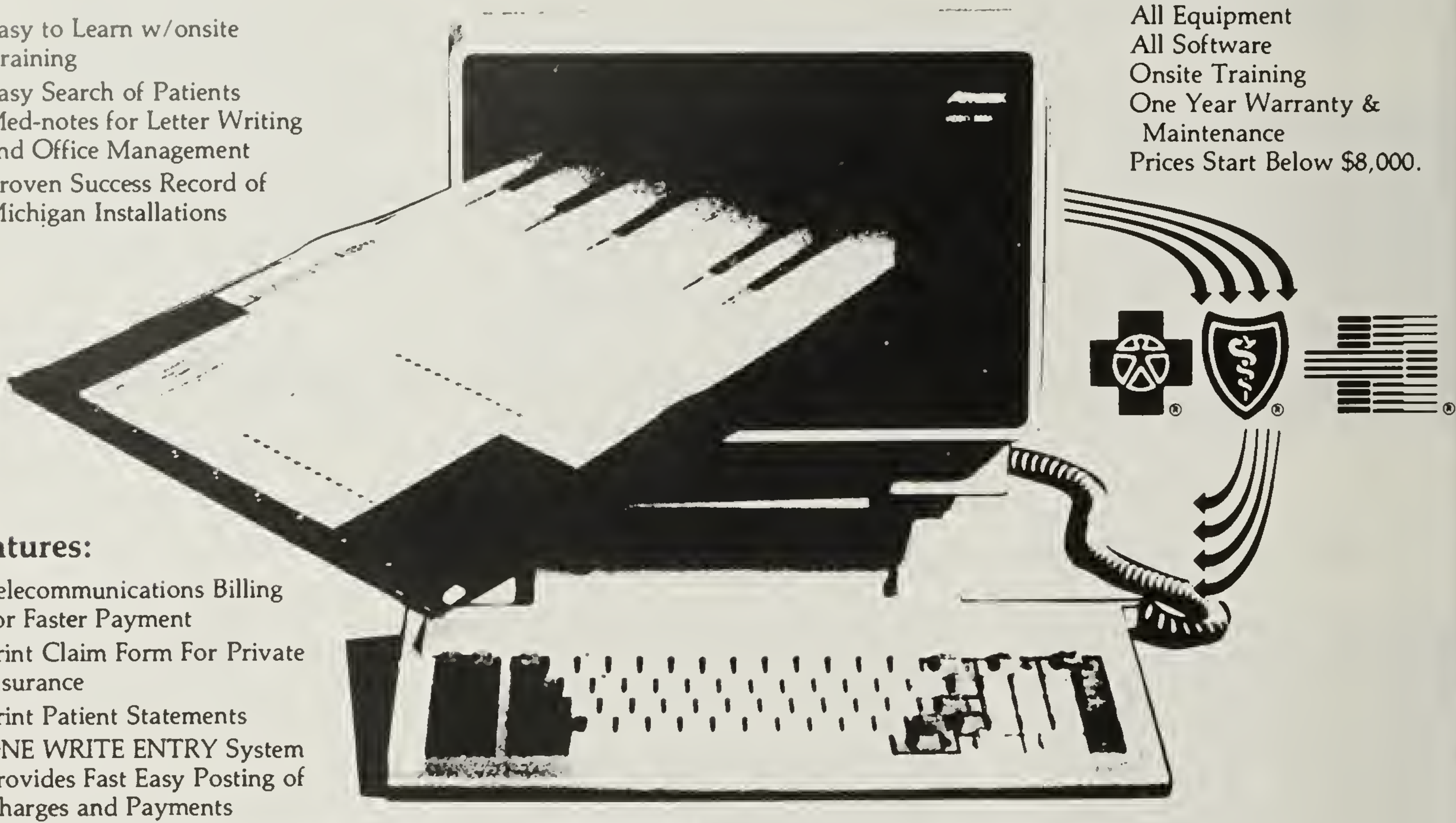
The cost of an unhealthy workplace is high. It has been estimated that premature death may cost businesses $2.5 billion per year. Costs for job dissatisfaction and low morale may be more difficult to equate than the cost of absenteeism due to diseases caused by unhealthy lifestyle; but many of us would agree that loss of time on task can be very costly.

Health promotion programs, which include educational programs, health assessments, employee assistance programs and other behavior change support systems can only help to increase the health of participants.

School districts are a natural setting for wellness programs for many reasons. They are labor intensive and affect many people. They also have existing facilities, have proven to be effective in networking with communities and always have been in the business of educating the public.

The benefits are many and the cost is low. Small districts, as well as large districts, have shown success. The limits may only be as far as one may be creative. Wellness is important for all, and the school workplace can indeed be a motivator! ■

The author is health education coordinator for the Gratiot-Isabella Intermediate School District and is an active participant in the Island Conference.



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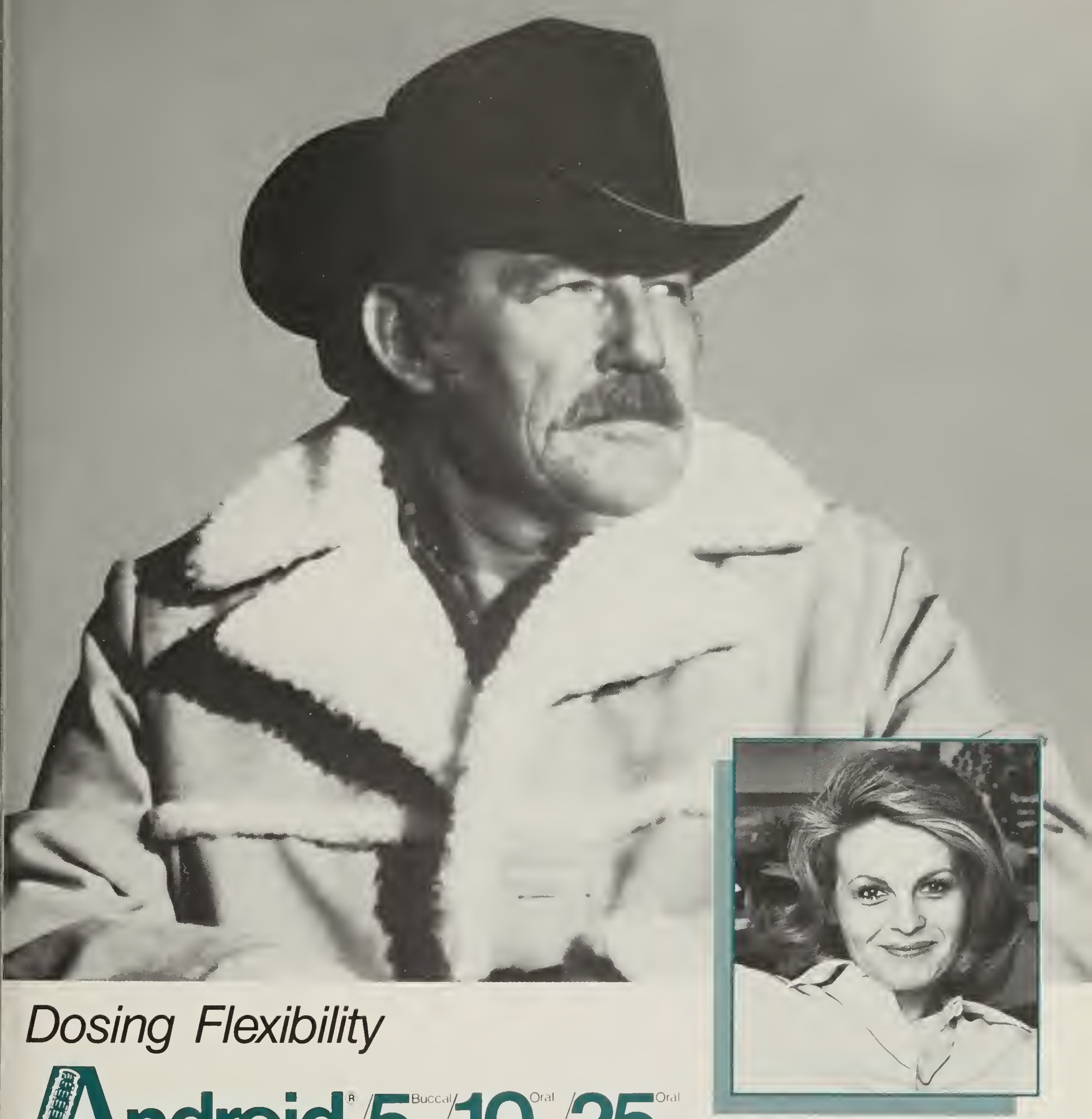

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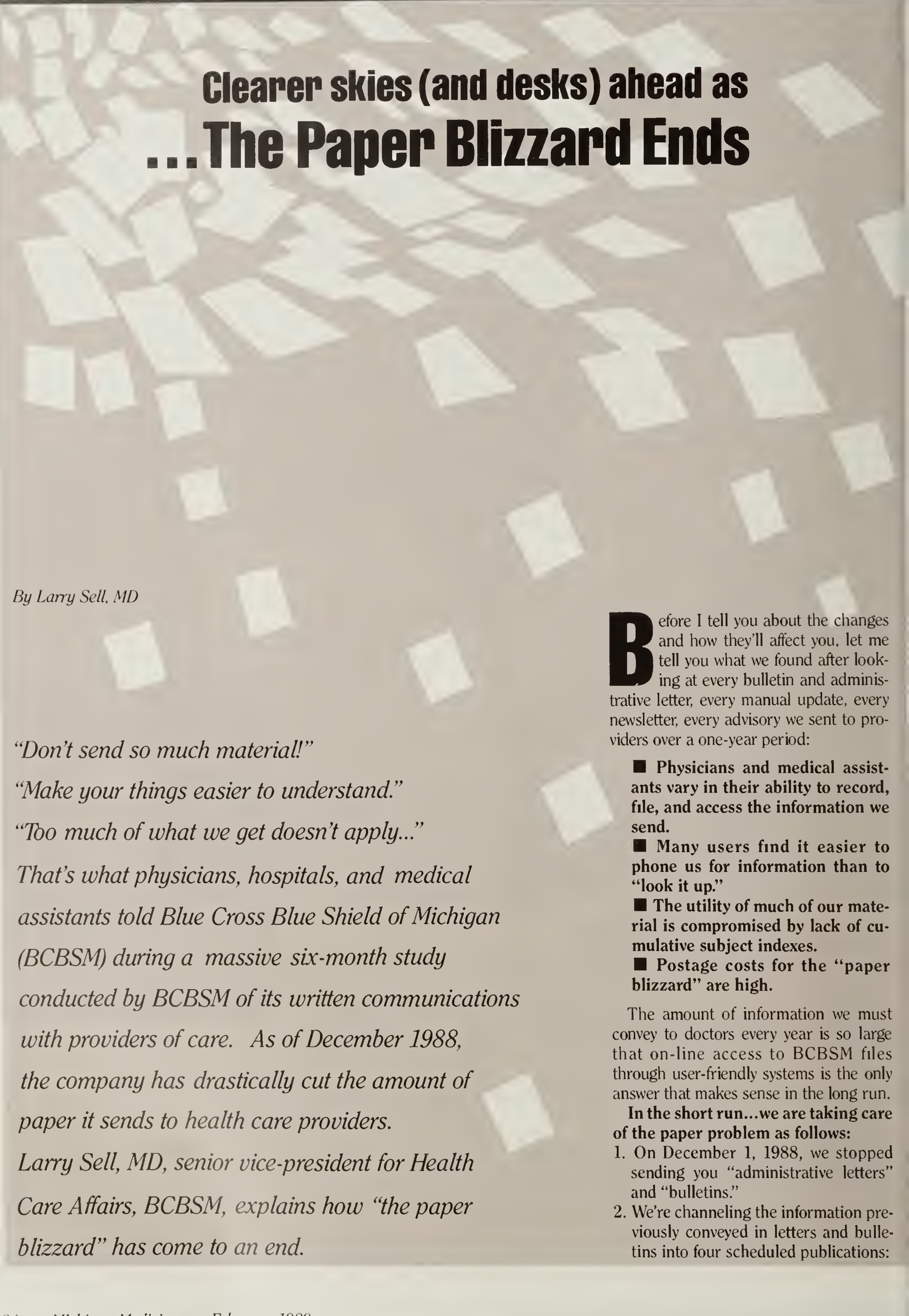

Clearer skies (and desks) ahead as ...The Paper Blizzard Ends

By Larry Sell, MD

"Don't send so much material!"

"Make your things easier to understand."

"Too much of what we get doesn't apply..."

That's what physicians, hospitals, and medical assistants told Blue Cross Blue Shield of Michigan (BCBSM) during a massive six-month study conducted by BCBSM of its written communications with providers of care. As of December 1988, the company has drastically cut the amount of paper it sends to health care providers.

Larry Sell, MD, senior vice-president for Health Care Affairs, BCBSM, explains how "the paper blizzard" has come to an end.

Before I tell you about the changes and how they'll affect you, let me tell you what we found after looking at every bulletin and administrative letter, every manual update, every newsletter, every advisory we sent to providers over a one-year period:

- **Physicians and medical assistants vary in their ability to record, file, and access the information we send.**
- **Many users find it easier to phone us for information than to "look it up."**
- **The utility of much of our material is compromised by lack of cumulative subject indexes.**
- **Postage costs for the "paper blizzard" are high.**

The amount of information we must convey to doctors every year is so large that on-line access to BCBSM files through user-friendly systems is the only answer that makes sense in the long run.

In the short run...we are taking care of the paper problem as follows:

1. On December 1, 1988, we stopped sending you "administrative letters" and "bulletins."
2. We're channeling the information previously conveyed in letters and bulletins into four scheduled publications:

The Record. Primarily for physicians, this newsletter was published once a month. Beginning December 1, 1988, it is published twice a month to assure you of timelier information.

Service News. This newsletter for professional providers other than physicians, previously distributed six times a year, has been doubled to once a month.

Hospital News. This new publication is being produced twice a month.

Facility News. A new monthly publication for facility providers other than hospitals.

All four are publications of record; that is, official communications you may rely on for accurate statements of BCBSM policies and procedures. And indexes of all four will be made available periodically. For faster, easier reference, the indexes will be compiled by subject, not article title.

Occasional Supplements

There may be times — seldom, I hope — when we need to communicate quickly with you about a benefit change, error correction, or other matter that can't wait for newsletter publication. In that case, we'll issue a newsletter supplement, and mail it separately.

Part of a Larger Effort

Eliminating letters and bulletins in response to your pleas for less paper is only part of a greater effort to improve our service to you. Another step: In 1989, we will regionalize our professional relations operation to recognize the special needs and situations of physicians and other providers of care in different parts of Michigan.

Patient demands, professional philosophies, even practice patterns may differ markedly from, let's say, Metro Detroit to Grand Rapids, or from the latter to Copper Harbor. Our new regional mechanisms will give providers in all areas a new vehicle for input to BCBSM policy and practices — and allow us to talk with you on your own ground. We'll tell you more about regionalization in the near future.

Making "the Mission" a Reality

In April 1988, our board of directors adopted a new mission statement committing BCBSM, among other things, "to cultivate with physicians, hospitals, and other providers, relationships characterized by mutual respect, trust, (and) confidence..."

Simpler communications, regionalization, and other programs in the planning stage are ways of making our mission pledge a reality...and, we hope, earning your trust and confidence in return.

Our president and CEO, Dick Whitmer, likes to quote State Attorney General Frank Kelley's reply to a statement of good intentions BCBSM made almost a year ago: "Action speaks louder than words."

It's an old piece of wisdom that holds fresh promise for a warmer, more productive relationship between BCBSM and Michigan's physicians and hospitals. ■

AIM HIGH

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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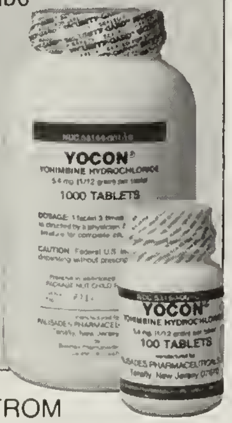

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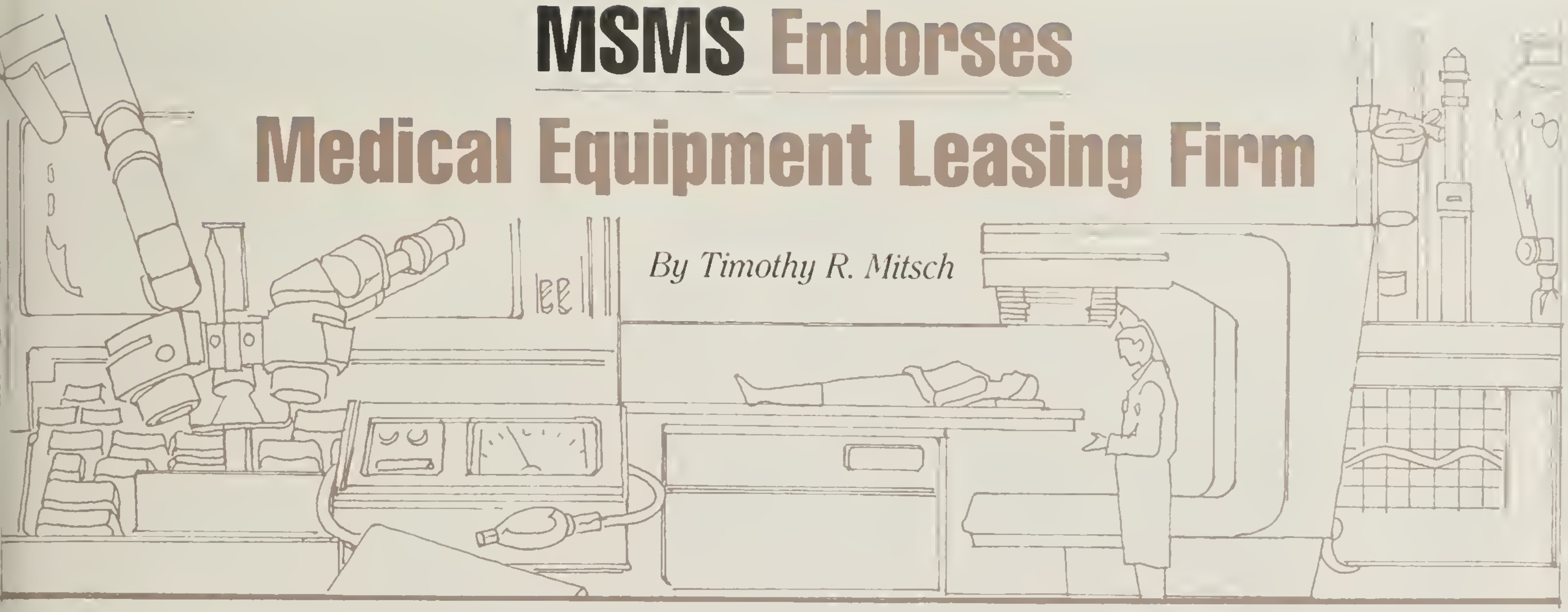
MSMS Endorses Medical Equipment Leasing Firm

By Timothy R. Mitsch



A standard argument in opposition to medical equipment leasing is that many physicians don't have the time it takes to research and establish a relationship with a leasing company. Physicians prefer to rely on existing sources of capital.

We are delighted to announce that the Michigan State Medical Society has performed the research and evaluation process and endorses the Medical Finance Division of Bell Atlantic-TriCon, Oakbrook Terrace, Ill., as the preferred lessor of medical equipment to all MSMS members. (The Society joins the medical associations of Texas, New York and Indiana in endorsing Bell Atlantic-TriCon, a leader in the area of medical equipment financing.)

Bell Atlantic-TriCon's Medical Finance Division brings some unique abilities to the problem of asset management.

First, the Division is an internally-funded company. That means it purchases all equipment out of its cash flow and maintains and services its leases for the entire term. The benefit to you is that you deal directly with the Division during the entire term of the lease and it responds to you in a timely and efficient manner. Also, because of Bell Atlantic-TriCon's strong corporate base, its internal cost of funds is such that you benefit from very competitive rates.

Second, its expertise in equipment appraisal and remarketing allows the Division to offer "residual" based pricing. Residual pricing can be extremely cost effective because it bases monthly payment amounts directly upon the value of the asset over time. You pay only for that portion of the asset that you use during the term of the lease.

Last, but perhaps most important, is the fact that Bell Atlantic-TriCon's Medical Finance Division specializes only in the financing of health care assets, both equipment and real estate. It maintains a sales force and designs programs specifically for individual physicians and physician groups.

Bell Atlantic-TriCon's Medical Finance Division has, in fact, developed a new equipment leasing program especially for MSMS members. The program offers significantly reduced rates with no hidden costs or padded commissions as with many vendor-offered leasing programs. In addition, the application/approval process has been vastly simplified.

If you are thinking of acquiring new medical equipment, we hope that you will consider leasing as an excellent financing alternative.

Why lease equipment?

If we were to look historically at the financing of healthcare assets, we would see that the most common methods have been the use of internally generated cash and debt financing, typically obtained through local banking institutions. These methods have worked well during less complex times and still work today in some cases. However, with rapid advances in technology, increased competition and a generally tougher economy, today's healthcare environment is much more complex. If you add Medicare's continually changing reimbursement rates, as well as national and local political concerns, the difficulties multiply.

Physicians today must maintain their competitive positions by offering higher quality services while holding the line on prices and reducing overhead. In short, physicians are being forced to become more effective asset managers by reviewing how all aspects of their business are implemented.

While not a new idea by any means, medical equipment leasing has become a very popular addition to the standard methods of financing healthcare assets. In the United States alone, over one billion dollars in medical equipment was acquired with lease financing in 1988. The reason for this popularity is that leasing makes good business sense.

When you lease an asset, you agree to pay a set price for the use of an asset for a specified period of time. Leasing provides you with the benefits of using the equipment, namely income generation and the offering of new services to patients, without the difficulties of ownership. A set term of use means that you pay only for the portion of the asset that you plan on using. This eliminates your risk of owning obsolete equipment. It also eases your cash flow because no down payment is required. In many cases, your monthly rental payments will be much lower than with typical bank financing. Leasing allows you the flexibility of returning the equipment, at a time in the future, when inflationary dollars are cheaper. Whichever way you choose, you have the comfort of making the decision at the end of the term when your level of need for the equipment has been established.

MSMS plan worth a try

If you are considering leasing medical equipment, we encourage you to compare rates with Bell Atlantic-TriCon's MSMS plan. ■

The author is MSMS program director for Bell Atlantic-TriCon. He will be handling all MSMS accounts.

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Unfortunately, an older person's response to medicines is less predictable than a younger person's. They can experience altered drug actions and adverse drug reactions.

So, if they don't tell you first, ask them what they're taking and if the medicines are causing any problems. Take a complete medications history including both prescription *and* non-prescription medicines.

Make it a point to tell them what they need to know — the medicine's name, how and when to take it, precautions, and possible side effects. Give them written or printed information they can take home, and encourage them to write down what you tell them.

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MEETING HIGHLIGHTS

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AMA

Michigan sent 15 delegates to the AMA Hospital Medical Staff Section meeting early in December. The delegation was led by Gary D. Maynard, MD, Kalamazoo, chairman of the MSMS Hospital Medical Staff Section.

Another meeting highlight for the Michigan delegation was the active participation of Krishna Sawhney, MD, Detroit, delegate who chaired HMSS Reference Committee C.

A highlight for the Michigan delegation was supporting Peter A. Duhamel, MD, Rochester, who took the AMA section dais as newly-elected national secretary. Doctor Duhamel was the first chairman of the MSMS Section.

1989 MSMS TOP ISSUES

MSMS has a plan of action for 1989 emphasizing its top issues. The Board has approved the plan, as introduced by MSMS President Fred W. Bryant, MD. "We are gearing for a high-energy year," said Doctor Bryant. Though professional liability leads the list, the other items are of key importance, also. They are:

1. Professional Liability:	MSMS is lobbying for protection of pension and profit-sharing plans in the event of bankruptcy proceedings. Speaker-elect Lewis Dodak has promised that pension protection legislation will be a priority in the 1989 session. MSMS also is exploring non-tort alternatives such as: — An at-fault system which would pay compensible claims similar to workers' compensation payments. MSMS is joined in this effort by the Michigan Hospital Association. — A program similar to the Swedish patient compensation, risk management and physician discipline systems. — Either mandatory arbitration or reduced health insurance premiums for physicians using the Michigan arbitration system. — A "bad baby" fund similar to the recently-enacted Virginia plan which helps compensate for birth-related injuries regardless of cause. MSMS is reviewing the plan as part of a demonstration projec for the Health Policy Agenda for the American People. — MSMS will continue to seek tort reform, pressing for removal of the exceptions to the cap on non-economic damages, further improvement in the statute of limitations, stricter qualifications for expert witnesses, evaluation of the modification of the joint and several rule, and countersuit legislation.
2. Integrated Licensure:	MSMS will lead in developing a new physician discipline structure similar to that of the State Bar.
3. Risk Management:	MSMS will inform Michigan physicians of how to minimize risks of lawsuits and how to take advantage of premium reductions for attending risk management seminars.
4. AIDS:	MSMS and the State Bar are developing a series of policy statements to protect physicians in management of AIDS patients. The policies will go to the legislature in early January. MSMS also leads in AIDS provider education efforts through a Michigan Department of Public Health grant.
5. Quality Health Care:	MSMS will continue to emphasize quality health care in the face of cost containment, in dealings with the new Governor's Task Force on Managing Health Care Costs, and in a joint effort with the Michigan Health Data Corporation and Michigan Hospital Association to develop a quality institute.
6. Physician Education:	MSMS will continue to provide continuing medical education, updates on preserving quality of care an on improving practice productivity.
7. Hospital Medical Staffs:	MSMS leaders will work to address nearly 20 hospital medical staffs at their general meetings in 1989. This will continue the "Physicians' Issue Presentations" initiated in 1988 which complement activities o the MSMS Hospital Medical Staff Section.
8. Third Party Payers:	MSMS will continue its advocacy efforts on behalf of Michigan physicians with Blue Cross Blue Shield Michigan, Medicaid, Medicare, and MPRO.
9. RBRVS:	MSMS will serve as convenor for discussions with the 34 recognized Michigan specialty societies, to discuss the Harvard Resource-Based Relative Value Scale (RBRVS). MSMS also will propose four informational forums with RBRVS experts.
10. Physician Recovery Network:	MSMS is seeking legislation which would create a joint MSMS/Board of Medicine program to divert physicians into treatment and grant them immunity while working in the program. MSMS is actively pursuing alternative funding for the Network sponsored by MSMS and MAOPS.
11. Elder Care:	MSMS will establish liaison with the Michigan Office of Services to the Aging and the Michigan Chapte AARP.
12. Media & Public Relations:	MSMS will increase efforts to serve as a reliable source of information to the public and media.
13. Non-dues Income:	MSMS will continue to improve its financial soundness by enhancing non-dues income. Hagadorn, Inc., a joint venture with MPMLC, is expected to provide a longterm real estate investment to enhance revenues. Physician Service Group, Inc., and the Peer Review Organization of Michigan, wholly-owned subsidiaries of MSMS, continue to increase non-dues revenues.
14. As Always:	MSMS will continue to emphasize county society activities, member communications, recruitment, benefits and political activity. As always, the goal of all MSMS activities is to ensure the availability of, and access to, quality medical care for the people of Michigan.

Three MSMS Sections will hold Meetings in March

MSMS Young Physicians Section

More than 60 young physicians, appointed as delegates and alternate delegates by their respective county medical society presidents, will travel to the Sheraton Inn, Lansing, to attend the First Annual Meeting of the MSMS Young Physicians Section. Young physicians who are not delegates or alternate delegates are invited to attend the meeting but will not have voting privileges.

Agenda highlights include the introduction of resolutions, the election of members to the Section's Governing Council, and a variety of presentations given by noted speakers.

Featured speakers include:

Dhiraj N. Shah, acting Michigan insurance commissioner, who will discuss the Michigan insurance climate.

Kirk B. Johnson, JD, general counsel to the AMA, who will provide an update on pertinent legal issues.

Also scheduled to speak are **Richard A. Stone, MD,** Section chairman, and **Frank B. Walker, MD,** chairman of the MSMS Board of Directors, and member of the AMA Board of Trustees. Doctor Walker will discuss, "The Young Physician's Challenges."

For meeting details, contact Linda Munson at MSMS headquarters.

MSMS Hospital Medical Staff Section

The Fifth Assembly Meeting of the MSMS Hospital Medical Staff Section will be held March 11 at the Ritz Carlton Hotel, Dearborn.

William R. Fifer, MD

William R. Fifer, MD, a well-known expert and consultant to hospitals and professional associations worldwide, will address meeting attendees on "The Hospital Medical Staff of 1999." The presentation will project what the hospital medical staff will be like in the next decade, organizationally and functionally, based on the evolution of the medical staff function to the present time.

Board-certified in internal medicine, Doctor Fifer devoted 15 years to multispecialty group practice before returning to the University of Minnesota in 1970 to pursue a second career in academic administration. He was at InterStudy for two years working on HMO/IPA development. He has served as a consultant and faculty for many national professional organizations including JCAHO, AMA, AHA, ACHE and the US Department of Health and Human Services.

For meeting details, contact F. B. "Tom" Plasman at MSMS headquarters.

MSMS Section for Graduates of Foreign Medical Schools

The first annual meeting of the MSMS Section for Graduates of Foreign Medical Schools will be held March 17-18 at the Ritz Carlton Hotel, Dearborn.

The organizational meeting will be the first such for graduates of foreign medical schools in the country.

Delegates will hear noted speakers, attend a gala international dinner, and act on resolutions to be sent for final action at the MSMS House of Delegates.

Featured speakers include:

Alan Nelson, MD, president-elect, American Medical Association.

Palma E. Formica, MD, president and chairman of the Board, Medical Society of New Jersey.

Robert L. Volle, PhD, president, National Board of Medical Examiners.

For registration details, contact Judy Marr at MSMS headquarters.

First Annual MSMS Young Physicians Section Meeting
Thursday, March 2, 1989
9:00 a.m. to 5:00 p.m.
Sheraton Inn, Lansing

MSMS Hospital Medical Staff Section Fifth Assembly Meeting
Saturday, March 11, 1989
8:00 a.m. to 5:00 p.m.
Ritz Carlton Hotel, Dearborn

MSMS Section for Graduates of Foreign Medical Schools
Organizational Meeting
March 17-18, 1989
Ritz Carlton Hotel, Dearborn

MSMS Endorses Collection Program

By Marilyn Seams

The Michigan State Medical Society has turned a losing situation into a win-win-win situation.

The Problem: The millions of dollars in unpaid debts MSMS members collectively have on their books, often after insurance companies have paid their portions.

The solution: MSMS has encouraged two of its endorsed services – IC System, Inc., St. Paul, Minn., and Medical Billing Service (MBS), Southfield, Mich. – to combine their efforts into an innovative collection program.

The results:

- MSMS members now have an IC System collection program – called MediCollect – that is specifically designed to fit their needs.
- MBS is able to offer its clients another specially-designed program.
- IC System can improve its services to clients because it is getting notice of debts earlier, which means they are more collectible.
- MSMS has the satisfaction of seeing members benefit from a program it was instrumental in developing.

How The Program Was Developed

The problem came to light at an MSMS conference in 1987 when John Richards, general manager, MSMS subsidiary operations, and Mike Magliocco, president, Computers Diversified Inc., discussed physicians' concerns about overdue accounts. (Computers Diversified is the parent company of Medical Billing Service.) Richards suggested Magliocco contact IC System, a national collection service that MSMS has endorsed since 1979.

When MBS officials visited IC System's home office in February 1988, both companies were impressed with the possibilities of providing a joint service that would connect IC System with physician offices through the MBS computer network.

Working closely with both MSMS and MBS, IC System has developed a computer-based collection program called MediCollect. MSMS laid down several guidelines for the MediCollect program. The program had to be:

1.) Easy for physicians to use.

2.) A better collection service than is available in the open marketplace.

3.) More effective than regular collection programs.

4.) Less expensive than other collection programs.

5.) Able to address the special concerns that physicians have regarding collecting from patients.

By September, IC System was ready to test the MediCollect program with a limited number of clients. Now the service is available to all MSMS/MBS members.

The MediCollect program eliminates one of the biggest collection roadblocks physician offices have: how to routinely submit overdue accounts for collection without surrendering control on what bills to send to collection or taking an inordinate amount of staff time.

Program Is Easy To Use, A Timesaver

MediCollect is a simple-to-use collection program that saves some clinic offices as much as two days of staff time a month. Here is how it works:

The patient's accounts are already on file on the MBS computer. Once a month, the MBS terminal screen in the physician's office shows all the accounts that are a certain number of days overdue. (The doctor decides how many days, typically 90 or 120). By simply touching a code, the doctor's office staff person selects which accounts are to be sent to IC System for collection. The MBS computer relays this information to the IC System computer, and the collection process begins.

After an account is selected for collection, MBS freezes the account history intact and sends no more statements to the patient.

A special team of IC collectors, who are experts in medical accounts and insurance issues, takes over. When the patient pays his bill, IC System deducts its commission, which is lower than its standard fee, and sends the balance to the doctor's office.

Every month, IC System sends the doctor a status report on all accounts in collection.

For the doctor's office, there are no forms to fill out, no additional records to keep, no need to go back through the books to pull out overdue accounts. This can be a major timesaver. Moreover, it catches delinquent accounts that might otherwise be overlooked until they are so old, they are very difficult to collect.

Program Comes With Training Kit

To help launch the MediCollect collection program, IC System has prepared a special introductory and training kit, which includes a computer demonstration diskette. IC System also has developed other educational materials for MBS to use with its clients.

A Look At The Company

Although MediCollect is a new program for IC System, the company itself is one of the most experienced in the collection industry. IC System was founded in 1938 and has grown into a nationwide company serving clients in all 50 states. It is one of the largest privately-owned collection agencies in the nation.

Almost since its beginning, IC System has worked closely with business and professional associations and currently is endorsed by almost 1,200 state associations. More than half of these associations are health care related. Because of its relationships with associations, IC System has been able to develop the types of collection programs that members desire. For example, IC System makes its services available to all association members regardless of where they are located, in rural as well as urban areas.

IC System meets the requirements of all applicable state and federal legislation, and its code of ethics goes beyond what is required of it legally. Its collectors are professionally trained in effective, psychologically-sound collection techniques.

The MediCollect collection program is one more reason why your membership in MSMS is a smart investment.

How To Obtain More Information

If you are already using the Medical Billing Service and are interested in the MediCollect program, you may contact IC System's MediCollect Customer Service team at its toll-free number: 800-421-3422. If you are not currently using MBS, contact John Richards, Physicians Service Group, at (517) 337-1351. ■

The author is communications manager for IC System Inc., St. Paul, Minn.

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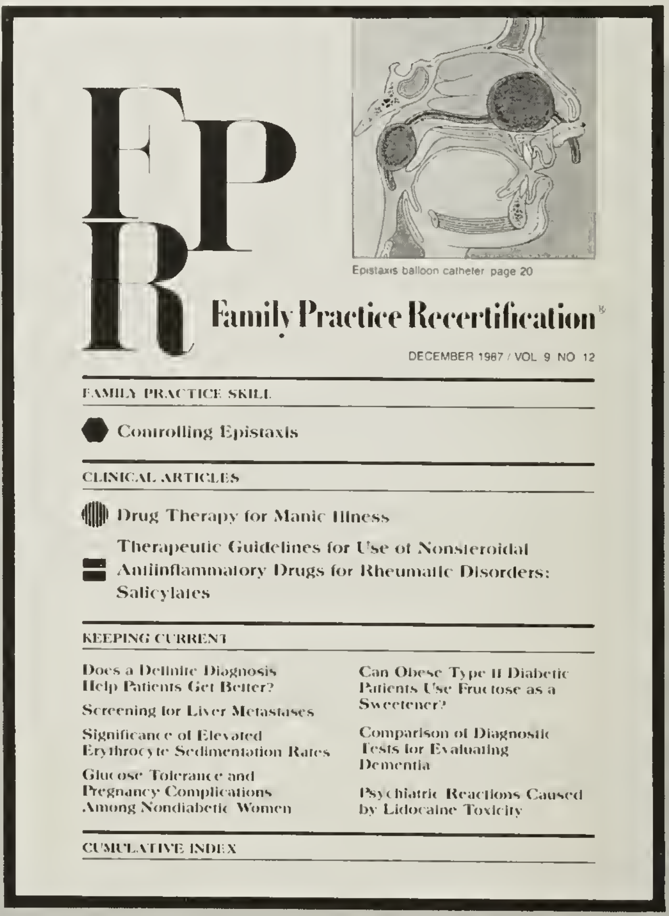

FPR

Epistaxis balloon catheter page 20

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CUMULATIVE INDEX

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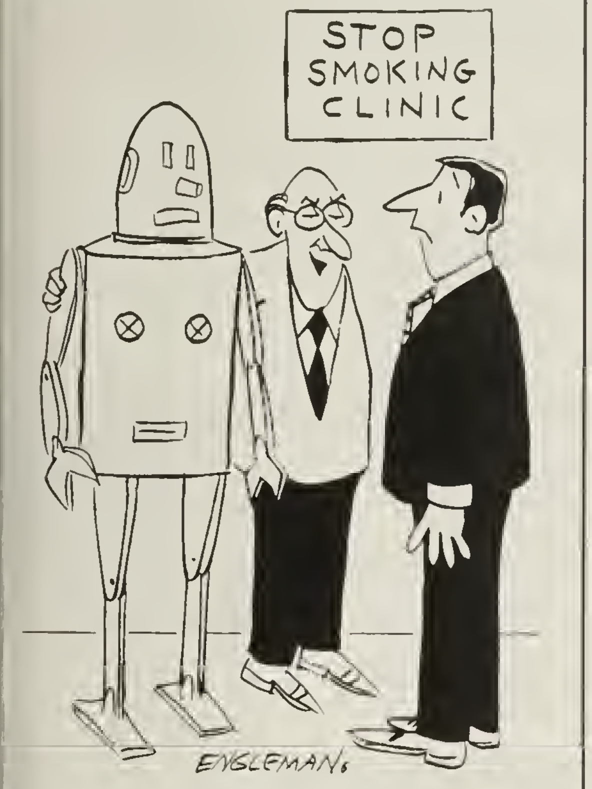

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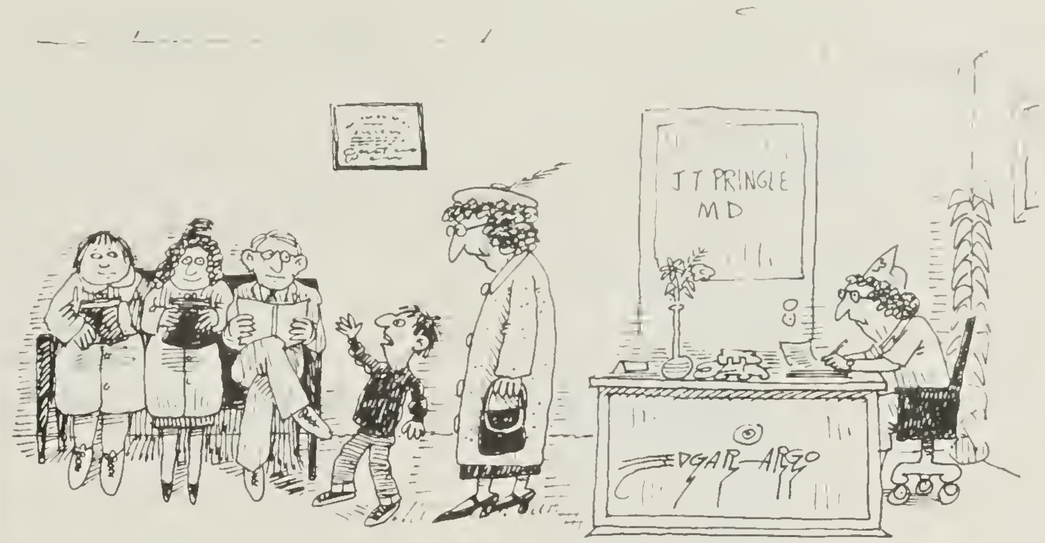

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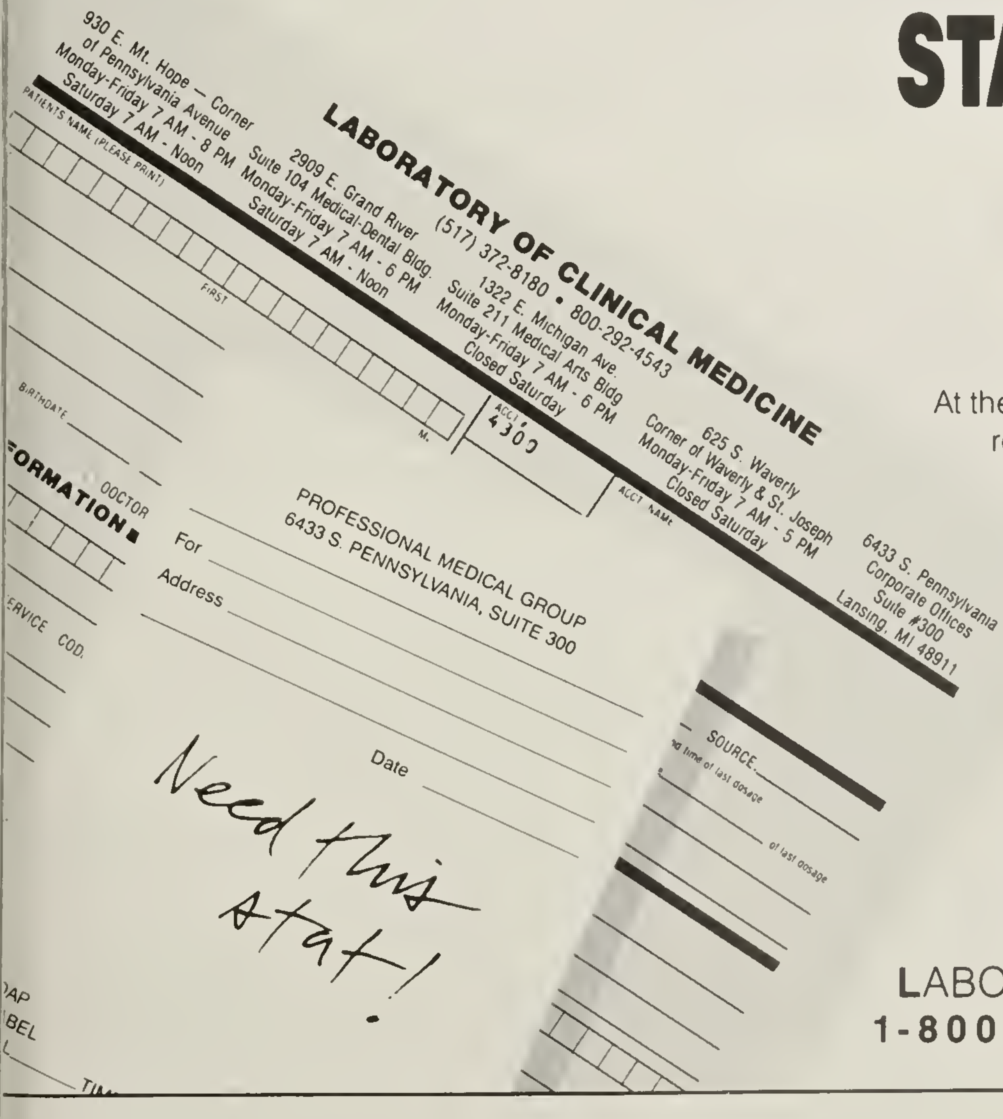

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Jeffrey M. Altshuler, MD — TS/GS
2799 W. Grand Blvd.
Detroit, 48202

Paula M. Berg, MD — AN
2105 Andenne
Ann Arbor, 48105

Robert J. Bielski, MD — P
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Okemos, 48864

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425 Cherry St., SE
Grand Rapids, 49503

E. A. Boessenkool, MD — FP
461 Lone Pine
Sparta, 49345

John Cantor, MD — PUD/IM
1000 W. University Dr. #203
Rochester, 48063

Jose A. Carrion, MD — DR
2425 Military St.
Port Huron, 48060

Amar Chawla, MD — CHP
P. O. Box 7522
Bloomfield Hills, 48053

Arunava Das, MD — ORS
110 N. Elm Ave.
Jackson, 49202

Mark J. Dykstra, MD — U
1631 Gull Rd. #110
Kalamazoo, 49001

Curtis D. Fandrich, DO — EM
P. O. Box 489
South Haven, 49090

Kenneth J. Fawcett, Sr., MD — PTH
132 W. First St.
Flint, 48502

James E. Flood, MD — FP
1330 Plainfield, NE
Grand Rapids, 49505

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700 Fuller Ave., NE
Grand Rapids, 49503

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Lansing, 48912

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Bloomfield Hills, 48013

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2808 Skyway Drive
Lansing, 48917

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Ypsilanti, 48197

Leroy T. Jackson, MD — IM
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Flint, 48503

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4488 Brooklyn Rd.
Jackson, 49201

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Port Huron, 48060

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963 Daisy Lane
East Lansing, 48823

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Grand Haven, 49417

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Paw Paw, 49079

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Somerset, 49281

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Grand Rapids, 49506

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Northville, 48167

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Fremont, 49412

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Jackson, 49201

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Birmingham, 48010

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601 Michigan Ave
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DEATHS

Leonard F. Bender, MD
Ann Arbor

Doctor Bender, chairman, Department of Physical Medicine and Rehabilitation, Wayne State University, died November 21 at the age of 63. Doctor Bender attended Haverford College in 1943, Princeton University in 1944 and Jefferson Medical College, Pennsylvania, where he obtained his medical degree in 1948. He was past president of both the Michigan and American academies of physical medicine and rehabilitation, and former president of the American Academy for Cerebral Palsy and Developmental Medicine.

Leslie T. Colvin, MD
Plymouth

Doctor Colvin died October 18 at the age of 88. He received his medical degree in 1923 from the University of Toronto. He received his postgraduate training at Henry Ford Hospital, Detroit. Doctor Colvin specialized in cardiovascular diseases and internal medicine. He also was a member of the Wayne County Medical Society.

Paul H. Feldman, MD
Southfield

Doctor Feldman, a psychoanalyst, died November 16 at the age of 73. A graduate of Wayne State University School of Medicine, Doctor Feldman was a fellow of the American Psychiatric Association and a former president of the American Academy of Psychoanalysis. He was a member of the American Medical Association and was formerly on the teaching staff at WSU School of Medicine.

Eugene Freitas, MD
Lincoln

Doctor Freitas, a radiologist at St. John Hospital, Detroit, for more than 30 years, died November 9 at the age of 74. A graduate of the University of Detroit, he received his medical degree from Wayne State University in 1941. From 1941-53, he was a Navy flight surgeon and radiologist. He joined St. John Hospital in 1953 and retired in 1984. He formerly served as president of the Michigan Radiological Society, was a former Michigan State Medical Society delegate, served as a director, Blue Cross Blue Shield of Michigan, was an American College of Radiology councilor and was chairman of the St. John Hospital radiology department.

Miguel Gatmaitan, MD
Pontiac

Doctor Gatmaitan, a Farmington Hills family physician, died November 7 at the age of 50. He was active in the Philippine Medical Association of Michigan, was a past president of the Novo Ecijanos of Michigan and was an active leader in the Filipino community. Doctor Gatmaitan, a Pontiac resident, was born in the Philippine Islands. He earned his medical degree from the University of Santo Thomas in Manila.

Frederick N. Hanson, MD
Boyne City

Doctor Hanson died October 20 at the age of 82. He graduated from St. Louis University School of Medicine in 1931, and was a flight surgeon in the US Air Force during World War II. Doctor Hanson had lived in Belleville and practiced medicine in Wayne. He was a founder of Annapolis Hospital in Wayne, where he was the first chief of staff. Doctor Hanson retired and moved to Boyne City in 1983.

John B. Hassberger, MD
Birmingham

Doctor Hassberger, a Birmingham pediatrician for 50 years, died October 28 at the age of 87. A 1935 graduate of the University of Michigan School of Medicine, he was on the staff of St. Joseph Mercy Hospital, Pontiac, from 1929 to 1973. He served as a lieutenant commander with the US Navy during World War II. Doctor Hassberger was a member of the University of Michigan Pediatric Society, Detroit Pediatric Society, the Oakland County Medical Society and the American Medical Association.

Richard Jakacki, MD
Livonia

Doctor Jakacki died November 24 at the age of 59. He was born in Canada and moved to Livonia in 1957 where he held a private practice for 30 years before retiring in 1987. An internist, he also was on staff at St. Mary's Hospital, Livonia.

A.C. Kerlikowske, MD
Ann Arbor

Doctor Kerlikowske, who served as director of the University of Michigan Hospitals from 1945 to 1969, died November 24 at the age of 88. He was a graduate of the University of Michigan Medical School, served as president of the American College of Hospital Administrators, Michigan Hospital Association, and Tri-State Assembly. He was a member of the Michigan Society for Pastoral Care, Greater Detroit Area Hospital Council, Washtenaw County Medical Society and the American Medical Association.

David W. Lindner, MD
Warren

Doctor Lindner, a Macomb Hospital Center neurosurgeon, died November 16 at the age of 64. He graduated from Wayne State University in 1946 and from Wayne State's medical school in 1951. A US Marine, he received the Distinguished Flying Cross and a purple heart while stationed in the South Pacific during World War II.

Samuel T. Ruskin, MD
Southfield

Doctor Ruskin died November 21 at the age of 93. Born in Russia, Doctor Ruskin lived in Detroit for more than 65 years. A 1923 graduate of the University of Toronto Medical School, he was a member of the American Psychoanalytic Association and the Wayne County Medical Society. Doctor Ruskin was on the staffs of Sinai and Providence hospitals.

Paul T. Salchow, MD, DPH
Columbus, Ohio

Doctor Salchow, a former epidemiologist for the City of Detroit, passed away November 10 at the age of 85. Doctor Salchow graduated from Wayne State University in 1932 and was former medical director of Herman Kiefer Hospital, Detroit. He was a member of the Wayne County Medical Society, Michigan Society for Prevention of Blindness, and a fellow of the American College of Hospital Executives.

MEETINGS

MSMS Meetings

March

2, First Annual MSMS Young Physicians Section Meeting, Lansing Sheraton Inn, Contact: Linda Munson, MSMS Young Physicians Section, (517) 337-1351.

8, MSMS Board of Directors Meeting, MSMS headquarters, Contact: William E. Madigan (517) 337-1351.

11, Fourth Annual MSMS Hospital Medical Staff Section Meeting, Ritz Carlton Hotel, Dearborn, Contact: F. B. "Tom" Plasman, MSMS Hospital Medical Staff Section, (517) 337-1351.

17-18, MSMS Section for Graduates of Foreign Medical Schools Organizational Meeting, Ritz Carlton Hotel, Dearborn, Contact: Judith E. Marr, MSMS Section for Graduates of Foreign Medical Schools, (517) 337-1351.

22-23, Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyond The Horizon" Hyatt Regency Dearborn, Contact: Sherry L. Fent, Chief, Physician Education, (517) 337-1351.

May

5-7, MSMS Board of Directors and House of Delegates, Hyatt Regency Dearborn, Contact: William E. Madigan, Executive Director, (517) 337-1351.

8-10, MSMS Auxiliary Annual Session, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, Account Executive, Physician Service Group, Inc., (517) 337-1351.

11, MSMS Conference on Sports Medicine, Hilton Inn, Lansing, Contact: Sherry L. Fent, Chief, Physician Education, (517) 337-1351.

AMA Meetings

March

2-4, On the Horizon: Regulation of Physician Training Programs, Biltmore Hotel, Coral Gables, Florida, Contact: Ira Singer (312) 645-4655.

May

10-12, First International Congress on Peer Review in Biomedical Publication, Congress Hotel, Chicago, Illinois, Contact: Bill Silberg (312) 645-4417.

Michigan Specialty Society Meetings

March

16, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, Contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225, (313) 839-3011.

April

18-21, Michigan Society for Respiratory Care, 31st Annual Respiratory Care Symposium, Amway Grand Plaza Hotel, Grand Rapids, Michigan, Contact: Michigan Society Respiratory Care, P. O. Box 950, East Lansing, MI 48826 or Caroline Kimmel at (517) 337-1351.

20, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, Contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225, (313) 839-3011.

27-30, Michigan Society of Medical Assistants, Annual Convention, Sheraton Inn, Lansing, Contact: Cathy Gunder, CMA, 7799 S. Clinton Trail, Eaton Rapids, MI 48827.

28, Michigan Thoracic Society/American College of Chest Physicians, Michigan Chapter, Annual Scientific Sessions, Sheraton Oaks Hotel and Conference Center, Contact: Robert E. Klimek, MD, 337 Chesterfield Parkway, East Lansing, MI 48823, (517) 334-2345.

May

4-5, Michigan Chapter, American College of Surgeons, "Coller Day Competition and Scientific Session" Sheraton University Inn, Ann Arbor, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950, (517) 337-1351.

June

1-2, Michigan Occupational Medical Association Spring Scientific Seminar, Bay Valley Hotel and Resort, Bay City, Contact: John Bernick, MD, 20900 West Road, Woodhaven, MI 48183, (313) 671-7251.

3, Michigan Society of Pathologists Spring Meeting, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950, (517) 337-1351.

22-25, Michigan Otolaryngologic Society, Annual Statewide Meeting, Contact: Karen Turner, Wayne County Medical Society, 1010 Antietam Road, Detroit, MI 48207, (313) 567-1640.

National Specialty Society Meetings

February

24-3/1, American Academy of Allergy and Immunology, Annual Meeting, Convention Center, San Antonio, TX, Contact: American Academy of Allergy and Immunology, 611 E. Wells St., Milwaukee, WI 53202, (414) 272-6071.

27-3/3, Society of Toxicology, Annual Meeting, Atlanta Hilton & Towers, Atlanta, GA, Contact: 1133 15th St. NW, Suite 620, Washington, DC 20005 (202) 293-5935.

March

2-5, American College of Nuclear Physicians, Annual Scientific Meeting, Sheraton Bal Harbour, Bal Harbour, FL, Contact: American College of Nuclear Physicians, 1101 Connecticut Avenue, N.W., Suite 700, Washington, DC 20036, (202) 857-1135.

5-10, American Society for Neurochemistry, 1989 Annual Meeting: Research Communications and Symposia on Various Aspects of Neurochemistry, Hyatt Regency Hotel, Chicago, IL, Contact: (416) 962-1155.

6-10, American Society for Dermatologic Surgery, 15th Clinical and Scientific Meeting, Marriott's Harbor Beach Resort, Ft. Lauderdale, FL, Contact: American Society for Dermatologic Surgery, 1567 Maple Avenue, Evanston, IL 60201, (312) 869-3954.

8-10, American Society for Clinical Pharmacology and Therapeutics, 90th Annual Meeting, Opryland Hotel, Nashville, TN, Contact: American Society For Clinical Pharmacology and Therapeutics, 1719 Gallagher Road, Norristown, PA 19401, (215) 825-3838.

8-12, American College of General Practitioners in Osteopathic Medicine and Surgery, San Antonio, TX, Contact: (800) 323-0794.

11-16, American Society of Clinical Pathologists: College of American Pathologists, 1989 Annual Meeting, Hyatt Regency Hotel, Chicago, IL, Contact: American Society of Clinical Pathologists, 2100 W. Harrison Street, Chicago, IL 60612, (312) 738-1336.

19-23, American College of Cardiology, Annual Scientific Meeting, Hilton Inn, Anaheim, CA, Contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814, (301) 897-5400.

19-24, American Association of Pathologists, Annual Meeting, New Orleans, LA, Contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814, (301) 530-7130.

31-4/4, American Orthopsychiatric Association, 66th Annual Meeting, New York Hilton, New York, NY, Contact: American Orthopsychiatric Association, 19W 44th Street, New York, NY 10036, (212) 354-5770.

April

2-6, American Association of Neurological Surgeons, Annual Meeting, Washington, DC, Contact: American Association of Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068, (312) 692-9500.

2-6, American College of Surgeons, Spring Meeting, Marriott & Westin Hotels, Copley Plaza, Boston, MA, Contact: American College of Surgeons, 55 East Erie Street, Chicago, IL 60611, (312) 664-4050.

MEETINGS

4-6, American Laryngological, Rhinological and Otological Society, Annual Scientific Meeting, Fairmont Hotel, San Francisco, CA, Contact: The Triological Society, P. O. Box 155, East Greenview, PA 18041, (215) 679-7180.

6-8, American College of Obstetrics and Gynecologists, Antepartum Fetal Assessment, Grand Hyatt, New York, NY, Contact: American College of Obstetrics and Gynecologists, 600 Maryland Avenue SW, Suite 300, Washington, DC 20024, (202) 863-2543.

12-16, American College of Preventive Medicine, Annual Scientific Meeting, Westin Hotel, Atlanta, GA, Contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005, (202) 789-0003.

13-16, American College of Physicians, Annual Meeting, San Francisco, CA, Contact: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104, (215) 243-1200.

13-19, American Academy of Neurology Annual Scientific Meeting, Hynes Convention Center, Chicago, IL, Contact: American Academy of Neurology, 2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414, (612) 623-8115.

14-16, American Academy of Pediatrics, Pediatrics in Progress, Tropicana Hotel, Las Vegas, NV, Contact: American Academy of Pediatrics, 141 Northwest Point Blvd. Elk Grove Village, IL 60009 (800) 433-9016.

16-19, College of Osteopathic Healthcare Execs; American Osteopathic Hospital Association, Annual Meeting, Scottsdale, AZ, Contact: (703) 684-7700.

22-25, Society of Cardiovascular Anesthesiologists, 11th Annual Meeting, Washington State Convention Center, Sheraton, Seattle, WA, Contact: Society of Cardiovascular Anesthesiologists, P. O. Box 11086, Richmond, VA 23230, (804) 257-7154.

28-5/1, Association of American Physicians; American Society for Clinical Investigation, 1989 Annual Meeting, Sheraton, Washington, DC, Contact: Association of American Physicians, 660 S. Euclid Avenue, Box 8125, St. Louis, MO 63123, (609) 848-1000.

29-5/5, American Occupational Medical Association, Annual Scientific Meeting, Sheraton Boston, Boston, MA, Contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005, (312) 228-6850.

30-5/3, American College of Physician Executives, National Conference on Health Care and Management, The Grand Hyatt, Washington, DC, Contact: (813) 287-2000.

May

3-7, American Psychoanalytic Association, 78th Annual Meeting, Hyatt Regency at Embarcadero Center, San Francisco, CA, Contact: American Psycoanalytic Association, 309 E. 49th Street, New York, NY 10017, (212) 752-0450.

5-7, American Urological Association, Annual Meeting, Loew's Anatole Hotel and InfoMart, Dallas, TX, Contact: American Urological Association, 1120 N. Charles Street, Baltimore, MD 21201, (301) 727-1100.

6-12, American Psychiatric Association, Scientific Meeting, San Francisco, CA, Contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005, (202) 682-6000.

7-10, American Association of Plastic Surgeons Annual Meeting, Camelback Inn, Scottsdale, AZ, Contact: American Association of Plastic Surgeons, The Johns Hopkins Hospital, 601 N. Wolfe Street, Harvey 811, Baltimore, MD 21205, (301) 669-7601.

7-11, American Urological Association Annual Meeting, Infomart/Loews Anatole Hotel, Dallas, TX, Contact: American Urological Association, 1120 N. Charles Street, Baltimore, MD 21201, (301) 727-1100.

8-10, American Association for Thoracic Surgery, Annual Meeting, Sheraton/Hynes, Boston, MA, Contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

10-14, American Society of Hypertension, Annual Meeting, New York Hilton, New York, NY, Contact: (212) 644-0650.

11, American College of Emergency Physicians, Occupational Medicine, Holiday Inn Crowne Plaza, Atlanta, GA, Contact: American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911, (214) 550-0911.

11-14, American Geriatrics Society; American Federation for Aging Research, 46th Annual Meeting, Marriott Copley Place, Boston, MA, Contact: American Geriatrics Society, 770 Lexington Avenue, Suite 400, New York, NY 10021, (212) 308-1414.

13-17, American Society for Gastrointestinal Endoscopy Annual Scientific Meeting, Sheraton Hotel, Washington, DC, Contact: American Society for Gastrointestinal Endoscopy, Thirteen Elm Street, Manchester, MA 01944, (617) 927-8330.

13-19, American Gastroenterological Association Annual Scientific Meeting, Sheraton Washington and Shoreham Hotels, Washington, DC, Contact: American Gastroenterological Association, 6900 Grove Road, Thorofare, NJ 08086, (609) 848-1000.

14-17, American Thoracic Society Annual Scientific Meeting, Convention Center, Cincinnati, OH, Contact: American Thoracic Society, 1740 Broadway, New York, NY 10019, (212) 315-8778.

21-23, American Society of Clinical Oncology, Annual Meeting and Exhibit Show, Moscone Center, San Francisco, CA, Contact: American Society of Clinical Oncology, 435 N. Michigan Avenue, Suite 1717, Chicago, IL 60611, (312) 644-0828.

22-25, American College of Obstetricians and Gynecologists, Annual Meeting, Convention Center, Atlanta, GA, Contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024, (202) 638-5577.

28-31, American Pediatric Surgical Association, Annual Meeting, Hyatt Regency Inner Harbor, Baltimore, MD, Contact: American Pediatric Surgical Association, Johns Hopkins Hospital, Baltimore, MD 20105, (301) 955-6256.

June

11-15, American Society of Colon and Rectal Surgeons, Annual Meeting, Sheraton Centre, Toronto, Ontario, Canada, Contact: American Society of Colon and Rectal Surgeons, 615 Griswold, Suite 1717, Detroit, MI 48226, (313) 961-7880.

12-15, American Orthopedic Association, Annual Scientific Meeting, The Broadmoor, Colorado Springs, CO, Contact: American Orthopaedic Association, 222 S. Prospect Avenue, Park Ridge, IL 60068, (312) 823-7186.

13-16, The Society of Nuclear Medicine, Annual Scientific Meeting, St. Louis, MO, Contact: The Society of Nuclear Medicine, 136 Madison Avenue, New York, NY 10016, (212) 889-0717.

Other Meetings

February

21, Marquette-Alger County Medical Society, Quarterly Meeting, Holiday Inn, Marquette, Michigan, contact: Robert Manning, Executive Director, Marquette-Alger County Medical Society, P. O. Box 68, Marquette, MI 49855-0068, (906) 227-2913.

April

17-18, Thirteenth Annual Conference of the Michigan Association for Infant Mental Health: Expanding Our Approaches with Families — Attachment, Intervention, and Social Policy, Ann Arbor, contact: Ann Saffer, 2340 Hickman Road, Ann Arbor, MI 48105, (313) 994-8168.

May

23, Marquette-Alger County Medical Society, Quarterly Meeting, Holiday Inn, Marquette, Michigan, contact: Robert Manning, Executive Director, Marquette-Alger County Medical Society, P. O. Box 68, Marquette, MI 49855-0068, (906) 227-2913.

CATEGORY I COURSES

February

27-3/3, Microvascular Workshop for Otolaryngologists & Head and Neck Reconstructive Surgeons. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and American Academy of Facial Plastic and Reconstructive Surgery. **Contact:** Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 41 hours of Category I Credit.

March

8-10, A Symposium in Diabetes Care. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School and American Diabetes Association. **Contact:** Betty Phillips, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

9-14, 12th Annual Ophthalmology: Basic and Clinical Review Course. Location: Wayne State University School of Medicine, Detroit. **Sponsor:** Kresge Eye Institute of Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, 4-H University Health Center, 4201 St. Antoine, Detroit, MI 48201 (313) 577-1180. **Approved for:** 42 hours Category I Credit.

10, 1989 Craniofacial Pain Conference. Location: Tropworld Casino and Entertainment Resort, Atlantic City, New Jersey. **Sponsor:** Kovak-Thomas Public Relations, Inc. **Contact:** Margo Smith, Kovak-Thomas Public Relations, Inc., 315 W. 57 Street, New York, NY 10019 (212) 246-0540. **Approved for:** 7 hours Category I Credit.

12-14, Family Care: Research & Policy Agendas for the 1990s. Location: Kellogg Center at Michigan State University. **Sponsor:** MSU College of Nursing, College of Human Medicine, and MSU Family Care Study. **Contact:** MSU College of Nursing, A-230 Life Sciences Building, East Lansing, MI 48824-1317 (517) 355-6525. **Approved for:** 12 hours Category I Credit.

12-17, Emergencies in Medicine. Location: The Yarrow, Dunfey Resort and Conference Center, Park City, Utah. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201 (313) 745-3484. **Approved for:** 25 hours Category I Credit.

14-18, Family Practice-1989 Thirteenth Annual Spring Review Course. Location: Towsley Center, University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Department of Family Practice and the Michigan Academy of Family Physicians. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 34 hours Category I Credit.

22-23, 28th Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyond the Horizon." Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P. O. Box 950, East Lansing, MI 48826-0950, (517) 337-1351. **Approved for:** 12 hours of Category I Credit.

25-4/1, Facial Cutaneous Surgery: Mohs, Reconstructive, Cosmetic. Location: Copper Mountain Resort, Copper Mountain, Colorado. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology, Head and Neck Surgery. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 30 hours Category I Credit.

April

2, Cardiovascular Update & Early Cancer Detection. Location: Conference Center, Mt. Pleasant Inn, Mt. Pleasant. **Sponsor:** CME Program of Central Michigan Community Hospital. **Contact:** Mary Jane Post, CME Coordinator, Central Michigan Community Hospital, 1221 South Drive, Mt. Pleasant, MI 48858-3234 (517) 772-6700. **Approved for:** 7 hours Category I Credit.

3-5, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 22 hours Category I Credit.

13-14, Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 15 hours Category I Credit.

17-19, Contemporary Concepts in Total Joint Replacement. Location: The Sonesta Beach Hotel & Spa, Bermuda. **Sponsor:** University of Michigan Medical School, Department of Surgery. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

26, Current Women's Health Care Issues. Location: Genevieve U. & Donald S. Gilmore, Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road, Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. **Approved for:** 6 hours Category I Credit.

26-28, Advances in Computed Tomography and Magnetic Resonance Imaging. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 22 hours of Category I Credit.

CATEGORY I COURSES

May

11-12, The Restenosis Summit, An International Symposium with Live Demonstrations. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

12, 11th Annual ACP-Michigan Chapter Associates Meeting. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** American College of Physicians, Michigan Chapter. **Contact:** Jan Rival, MD, FACP, Henry Ford Hospital, Department of Internal Medicine, 2799 Grand Boulevard, Detroit, MI 48202 (313) 876-1895 or 876-2059. **Approved for:** 6 hours of Category I Credit.

14, Identification and Diagnosis of Mental Illness in the Developmentally Disabled. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road, Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. **Approved for:** 5.5 Category I Credit.

15-19, 17th Annual Spring Update: Advance in Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 34 hours Category I Credit.

19-20, Recent Advances in Cornea, External Disease, and Cataract: 61st Annual Ophthalmology Spring Conference. Location: W.K. Kellogg Eye Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

31-6/2, Current Topics in Blood Banking: 16th Annual Symposium and Workshops. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

June

1-2, Fifteenth Annual Symposium for Michigan Neonatologists and Neonatal Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Neonatology Service, Bronson Methodist Hospital, (616) 341-6469. **Approved for:** 7.25 hours Category I Credit.

7-10, The 7th Annual Clinical Laboratory Computer Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 15 hours Category I Credit.

18-23, 25th Annual Northern Michigan Summer Conference. Location: Shanty Creek – Schuss Mountain, Bellaire, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

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PRESIDENT'S PAGE

Meeting With The Press – an opportunity for physicians, not an ordeal

By Fred W. Bryant, MD

At the MSMS Leadership Conference, held in October 1988, a physician participating in a simulated media interview was heavily harassed by the course instructor, a newsman feigning hostility. Overcome by the intensity of interrogation – even in mimicry – the badgered doctor lost his composure. He vowed, "never again" would he talk with newspeople. I rose then (as I do now in print), to defend the feasibility of speaking out – and the merit of doing so.

As society grows increasingly complex, more issues of magnitude and importance surface. We physicians have much to give the world. In turn, we are obligated to relate to external forces.

MSMS actively involved in media events

Public exposure has become inevitable, communication essential, and public relations imperative. In fact, we find MSMS is talking things up in a big way. You may be surprised at the facts and figures involved.

1.) The all terrain vehicle safety presentation originated in the newsroom of the State Capital in May and included direct testimony from the Attorney General and Secretary of State of Michigan. It sparked 70 or 80 news stories, 20 to 30 radio interviews, initiated hundreds of public service announcements on dozens of television and radio stations, and culminated in the introduction of legislation by Senator John J. Schwarz, MD, (R-Battle Creek), to regulate the use of ATVs.

2.) The "Break the Silence" organ donor/transplant campaign, supported simultaneously by the Michigan Hospital Association, the Michigan Bar Association and MSMS, reached 50 news outlets the day of release. Twenty to 25 contacts later on resulted in supportive editorials in newspapers. Even my relatives in Wisconsin heard about this program. Seven billboard companies have donated 92 free spaces valued at $40,000 for display of our message in coming months.

3.) The Rural Health Information Initiative touched down at five far-flung sites and involved representatives of several hospitals at each locale, administrators, board members and staff physicians. It was conducted by the Michigan Department of Public Health and the Michigan Hospital Association in conjunction with local health departments and MSMS.

4.) The AIDS effort. Many doctors and other health professionals and lawyers worked several months to help the legislature prepare its AIDS package. The AIDS Speakers Bureau has made 300 presentations to 20,000 people in health related professions.

5.) Each year the MSMS Annual Scientific Meeting and the Michigan Conference on Maternal and Perinatal Health draw favorable press, TV and radio attention.

Physicians most qualified to address medical issues

I would be remiss if I failed to emphasize the fine spirit of cooperation of the people involved in these projects. The legislature should be commended for its patience and sagacity in relation to its AIDS legislation; the executive branch, and some of its principal officials and administrative agencies for their effort. The Michigan Hospital Association and the State Bar of Michigan were essential elements in advancing these public moves.

Thus, we see that the scientists armed with facts are a powerful force. Physicians are the ones most qualified to speak to medical issues. They are the best trained, best informed and closest to the problems. Of course, not all physicians are ideally suited for the job of serving as spokesperson, with the best temperament or disposition. But there are many more qualified than actually volunteer to meet with the news media.

Attitude is such an important factor in presentation. There has been much discouragement in medicine in recent years, but if somehow, magically, we could eliminate liability and third party payors, optimism about medicine would be at an all-time high, bullish beyond belief.

In speaking to colleague or citizen, I encourage you to think positively about yourself and your public projection.

By way of encouragement and reassurance, I tell you that my encounters with the media have been favorable. I may sound a bit like Will Rogers when I state, 'I have never had a bad session with a newsperson.'

There may be sensationalists or derogatory "heavies" out there, but not for me. The media have been courteous and kind to me and fair to the issues I have presented. I even can say they have quoted me accurately.

We have nothing to hide, and much to be proud of. In dealing with the media, be timely, topical, open and analytic, but not overly critical or censorious. There is no need to deceive, to stiff-arm or stone wall.

Newspeople are frequently in haste, not always in depth, often with their own angle (but willing to listen to yours), enamored of zingers, one liners, and 30-second summations. But they are animated and sincere.

In a sense, the physician poised on the brink of public presentation for the first time can be compared to Alice in Wonderland. He sees dimly through a veil of fears, peering as through a glass darkly. He is in need of real, rather than imaginary, images, a sharp refractive perspective which focuses clearly, and a reflective capacity to give luster and public image.

The journey is more an opportunity than an ordeal. So I suggest to you a "public" life. No more "never." Try it, it may be to your liking.

Medicine is a positive, productive profession. Maybe you can add to our image.

Doctor Bryant is MSMS president.

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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General. Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

Hypertension: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

Heart Failure: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy.

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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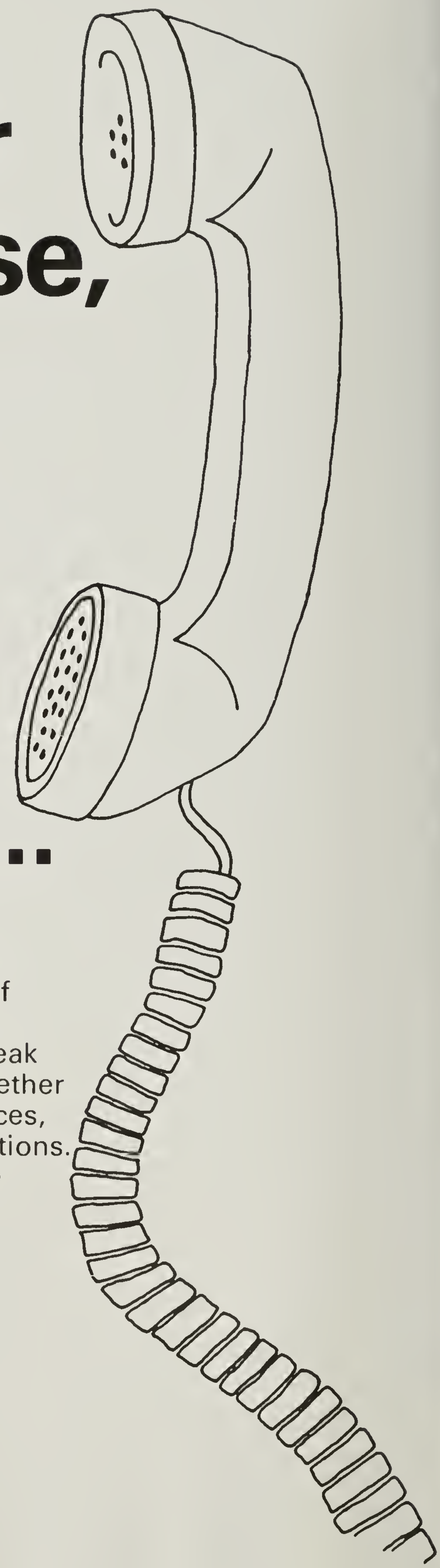

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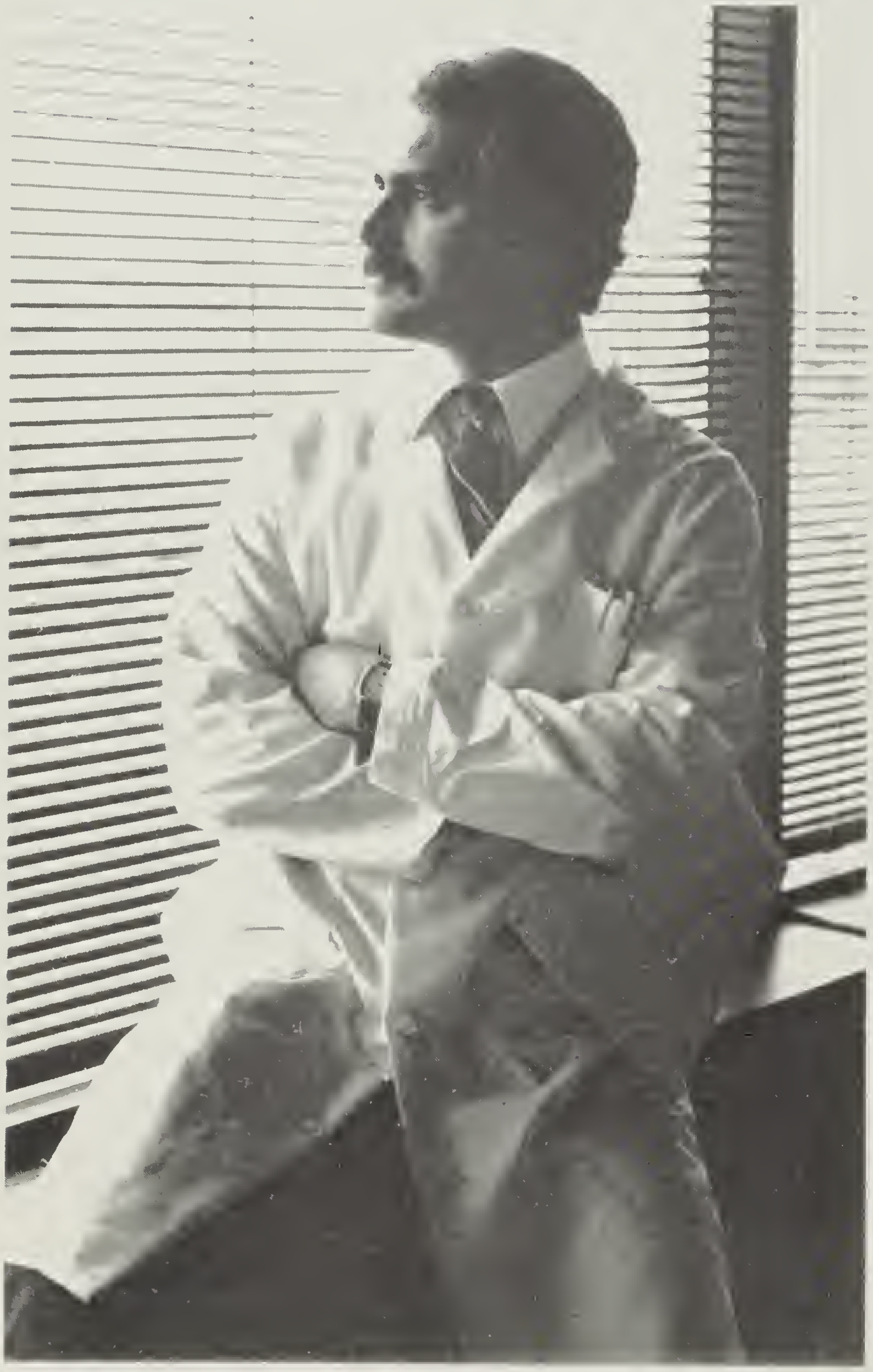

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MICHIGAN MEDICINE

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Cover Story

The percentage of those over 65, which barely numbered four percent in 1900, now exceeds 12 percent of our population, and will continue to increase through the middle of the next century. Currently, Michigan has in excess of one million older adults. Because MSMS recognizes this fact of life, and is paying close attention, the care of the aging is the subject of this month's cover story in *Michigan Medicine*. Included in the cover story: A report by James G. O'Brien, MD, chairman, MSMS Committee on Aging; a description of the AMA's position on caring for the needy elderly; an indepth report on a voluntary Medicare assignment program in Midland County; a look at the problem of long-term care, written by Samuel M. McMahon, MD; and finally, a description of upcoming training programs for Michigan physicians on elder abuse.

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Cover Illustration By: *Robert L. Brent.*

THE LOWER RESPIRATORY TRACT—
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Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci)
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS

Administer cautiously to allergic patients

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics It must be considered in differential diagnosis of antibiotic-associated diarrhea Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk Exercise caution in prescribing for these patients

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include
- Gastrointestinal (mostly diarrhea) 2 5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever) 1 5%, usually subside within a few days after cessation of therapy Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis, elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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IN MY OPINION

Health Care for the Aging Needs to be Approached Cautiously

By Marguerite Shearer, MD

Controlling health care costs while maintaining quality and increasing access — enigmatic assignments to say the least! What can we do?

One cause is the cost inflationary effect of first dollar coverage. Currently, 52 percent of working people have "free" access. It would behoove us to obtain extensive data on the utilization patterns of these people. In a 70,000-member HMO population with which I am familiar, those with first dollar coverage used 12 percent more services than other members with a similar benefit package. Once a large enough data base is accumulated, and if indeed the results of this small study are corroborated, the information should be widely disseminated to employers, unions, and the general public.

Perhaps we should encourage people to view their health coverage as insurance rather than prepaid entitlement to a wide variety of health services. Many physicians have commented that they are seeing an increasing number of "worried well" and very minor problems in members of prepaid, first dollar covered or minimal copay plans.

Health care coverage for the aging population of our nation needs to be approached cautiously, thoughtfully and carefully. How can you be "kinder and gentler" to older people while cutting medical costs? The process of medical decision-making is intriguingly complex.

Many factors other than clinical logic influence physicians in their prescription of medical care. One set of influences includes those related to physicians' own self-interest. In addition, their commitment to their patients' well-being plays a major role in medical decision-making. Decisions frequently incorporate the physicians' perception of the patients' own desire for care, their personal characteristics and convenience, and their economic well-being. As limitations on the social resources available for medical care are more widely recognized, physicians increasingly will face a third set of influences: consideration of what is best for society as a whole versus what is best for the patient as an individual. Certainly this will cause dilemmas of major proportion for physicians who have been trained and believe in a doctrine of doing as much as we can for every patient.

Mandatory assignment for physicians will likely get an abundance of "air time." The fact that more physicians in Michigan participate voluntarily either for all elderly patients or on a case-by-case basis doesn't seem to make a difference. It is apparent that mandatory assignment has created significant access problems for the elderly, particularly in rural areas. Indeed, mandatory assignment is health care rationing from the provider's side.

As advocates for our elderly patients, we shouldn't unreasonably avoid criticism. We need to be aware that more than 20 percent of children live below the poverty level, while less than 12 percent of elderly do.

From 1970 to 1986, benefits to the elderly escalated from $10.1 billion to $300 billion. During the same period, ADC stayed at $10 billion. A recent report stated that after the average person has been retired three-and-a-half years, they have received all they paid as Social Security tax; after 12 years retirement, they have received all the income tax they paid while working. To date, the seniors have refused a means test; they are politically active and astute.

As a society, we must keep our perspective. There are many other issues that require money — uninsured, underinsured, environmental problems, roads, bridges, water, waste disposal, etc. Balancing all these needs will require information, knowledge and wisdom. ■

Doctor Shearer is a member of the MSMS Committee on Publications.

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Letters from Our Readers

One MSMS member seeks reasons for increases in group insurance rates

The following letter is typical of MSMS members' questions about recent group health insurance premium increases.

In the field of health insurance, Blue Cross and Blue Shield of Michigan (BCBSM) appears to be taking lessons from the notorious malpractice insurers. If the latter can successfully devise escalating costs and demand skyrocketing premiums, well then, they (BCBSM) seem to be reasoning, "Why can't we?" At this time, they have not reached the outrageous levels of the malpractice companies – not just yet, but they are working on it. Unfortunately, nobody seems to be appropriately concerned, and the Blues are having it all their way, with hardly a protest from the Michigan State Medical Society (or from the County level).

One year ago, in January 1988, when the insurance office at MSMS headquarters was queried as to the hefty increase in the premium at that time, the administrative office replied, "Pay no attention to it. It's a mistake. It will be corrected shortly; and the letter will be sent to all members clarifying the situation." Sad to say, by March 1988 there was neither a letter nor a significant adjustment in the premium.

This past December, with the notice of the January 1989 premium showing another whopping increase, there was a letter attached from the chairman of the MSMS Committee on Liaison with BCBSM. This letter duly acknowledged that there was a sizeable increase in premium, which seemed to have taken the Committee by surprise, and further suggested that perhaps something might be done about it. Indeed, as a matter of great pertinence, the chairman of this Committee has had considerable first-hand experience in County and State organizational affairs. For a person (or a group, such as the Committee), to be actively working for the member doctors, it should be incumbent upon him (or them) to be forthright and outspoken against improper actions or abuse of privilege.

According to Webster's 33rd New Encyclopedic Dictionary of the English Language, the term "double-talk" is defined as language that appears to be earnest and meaningful, but in fact, is a mixture of sense and nonsense; often deliberately ambiguous. In contemporary parlance, the term has been modified by the media to "doublespeak."

This letter that I refer to, which was sent to all subscribers to the State BCBS program, begins by saying, "Regrettably, the new rates from BCBSM were not received in time for the MSMS Group Insurance Trustees to review them." It is pertinent to project: When did the Group Insurance Trust of the MSMS have its last meeting? Did they discuss the probability of the coming rate to be excessive? Was it not their responsibility to be aware of the ensuing rate change?

The letter continues: "In order to maintain the fiscal integrity of our experience rated groups, the Trustees feel it is necessary to proceed with the uninterrupted billing cycle on these tentative rates." This is their way of telling us that, even though they were remiss in learning about the excessive increase before it was presented to the members, we should acquiese and pay this puffed-up premium, so BCBSM would not be angry with us. Also, just what are the financial realities of our experience rated groups, and do they justify the marked increase of assessment?

The letter continues, the Trustees will now "analyze the proposed 1989 rates along with several possible new options for the MSMS-sponsored program. The new options, along with the final rates, may provide a degree of relief from the premiums on the bill you have just received."

The English translation means that there is not much they have done, nor will they be able to impose upon BCBSM some adjustment in their rates. Apparently, they are talking about closing the barn door after the horse has run away.

"As soon as possible, we will communicate to you the Trustee's decision regarding new options, benefit changes and the final rates. This information will be provided to you with adequate time to make your decision regarding the type of coverage or options you may want to select for your 1989 coverage."

The art of doublespeak tries to obscure the following pertinent points:

1.) We didn't do our homework with BCBSM and we were caught completely unaware of the excessive increase in the 1989 premium.

2.) Be good boys and girls and pay this premium, so that BCBS will not get angry with us if we raise some searching questions concerning the validity and necessity for such increasingly larger premiums over the past several years. How much does it take to satisfy the corporate structure at the Blues?

3.) While the premium increases are being paid (passively), we will try to look into some optional methods which the shameful premium increases will be softened or directed into alternative pathways. Under no circumstances do we want the officers at BCBSM to feel we are unhappy with their rate increases; or that we on the Committee are not working to protect the interests of the members.

I do not agree. Perhaps by exposing and publicizing the authoritarian way BCBSM establishes their rates, and the indifference and timidity of the members of the MSMS Group Insurance Trust, we may in time attain for our benefit an equitable premium adjustment.

It is noteworthy that the chairman of the MSMS Group Insurance Trust has also chaired the MSMS Awards Committee. With the proverbial tongue in cheek, it would not be inappropriate for the latter Committee to consider an award for a conspicuous exercise in the mastery of the art of doublespeak.

Seymour Krevsky, MD
Birmingham

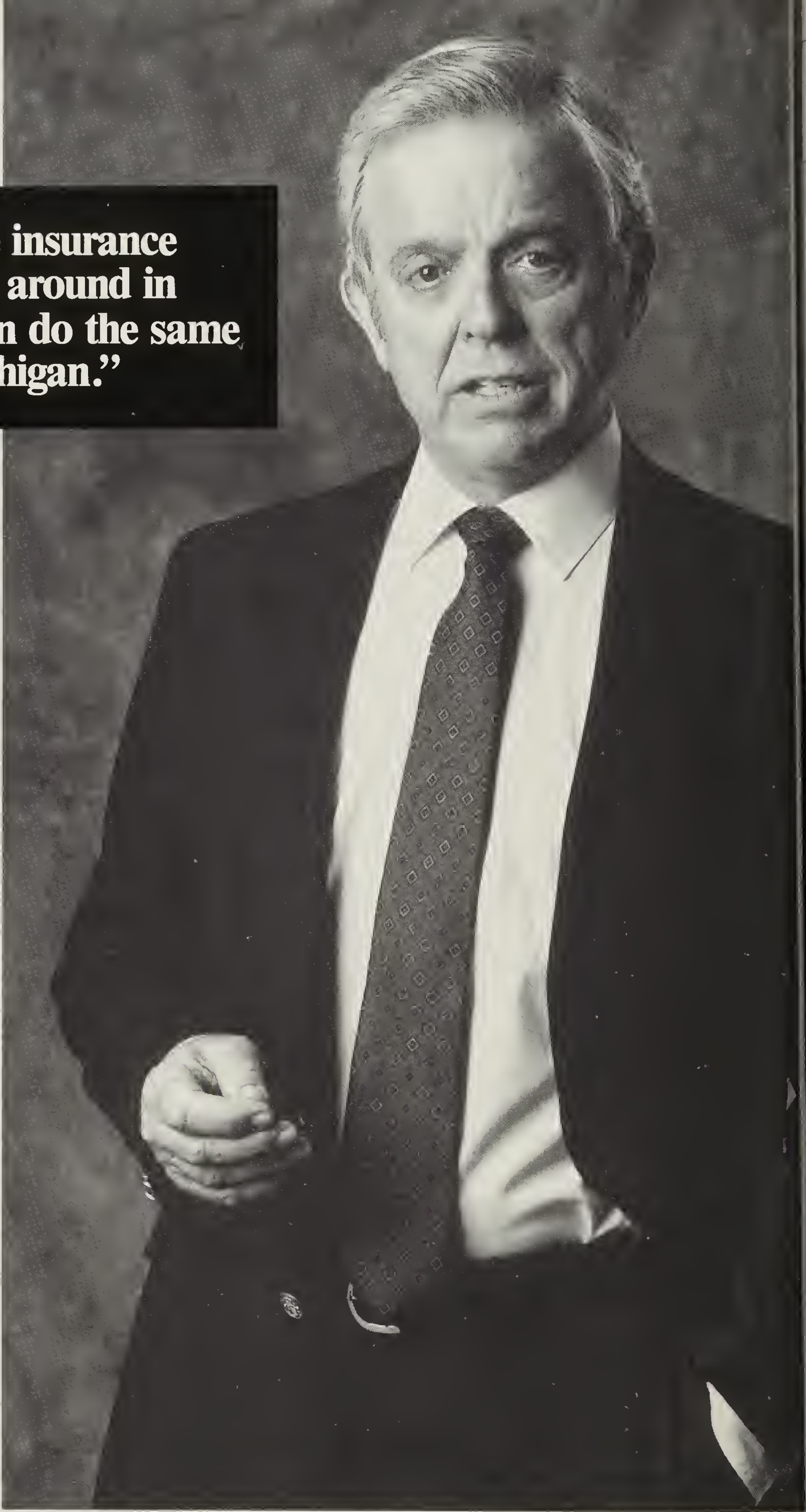
MSMS Group Insurance Trustees anticipate long-term rate relief

Editor's note: Below is a verbatim reprint of the letter sent by B. David Wilson, MD, chairman of the MSMS Group Health Insurance Trust, to all MSMS members in February regarding BCBSM's new rates.

Since MSMS was notified of the new Blue Cross Blue Shield rates for 1989 in December, the Group Insurance Trustees have investigated the reasons why such a large increase was requested. After studying this matter, several things are apparent. First, the magnitude of the increase is not unusual for either Blue Cross Blue Shield or for private insurance carriers this year. Numerous other groups were surveyed and the rate increase is similar in each case. Secondly, the MSMS group is an experience rated group. This means the premiums reflect in a large part the actual cost of paying for the health care of the group. Thirdly, the utilization of the services, especially in the area of inpatient and outpatient psychiatric care and prescription drug benefits, has increased considerably in 1988. The MSMS health insurance group is, in most cases, at or above the average for similar groups in the utilization of services.

The Trustees concluded that rather than taking a piecemeal approach to modifying benefits, with no assurance that these modifications will produce savings, it is better not to make any changes in the coverage at this time. MSMS is reviewing its group insurance program and will be proposing a revamping of the current options for the program in 1990. MSMS expects the overall review of the program will produce long-term rate relief and still maintain a high quality health insurance program.

“Claims-made insurance helped turn things around in California. It can do the same for Michigan.”



David Rubsamen, Physician/Lawyer
Leader in California malpractice
reform since 1970.

15 years ago, California doctors had the same concerns about claims-made insurance that Michigan doctors have today. Is it right? Should they switch? What about the tail?

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And, “It works extremely well!” says noted physician, lawyer, and lecturer, Dr. David Rubsamen.

In fact, he says, “In the mid-’70s, California was among the worst malpractice states. Since then, we have become the model.” And he sees “claims-made insurance, doctor-owned companies, sound underwriting, and continued tort reform as the best solution today for the malpractice problem.”

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MEDICAL NEWSFRONTS

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Patients needed for study

Beaumont Hospital

The Clinics of Preventive and Nutritional Medicine of William Beaumont Hospital are seeking volunteers for a drug study.

Participants in the study must be diabetics who have high cholesterol and who control their diabetes with diet or with oral medications.

For more information about the study, contact the Clinics of Preventive and Nutritional Medicine at (313) 646-6500.

Kughn Clinical Research Center

The Kughn Clinical Research Center, University Hospital, University of Michigan, is performing a double-blinded three-arm study of Metformin and placebo, Metformin and glyburide, or glyburide and placebo in moderately obese diabetes poorly controlled on sulfonylureas. The patient characteristics include:

- Age 40 to 70.
- Fasting blood sugar more than 140 without polys or weight loss.
- Normal renal and liver functions.
- No active cardiac disease.
- Non-insulin dependent diabetes.
- On maximum sulfonylurea doses.
- Either sex: women no pregnancy potential.
- Weight more than 120 but less than 170 percent of ideal.

For further information, contact: Imitiaz Kazi, Endocrinology & Metabolism, 3920 Taubman Center, Box 0354, Ann Arbor, MI 48109, (313) 936-5032. ■

U-M receives $730,000 grant for AIDS research

The University of Michigan has received a $731,590 grant from the National Institutes of Health (NIH) that will significantly strengthen its AIDS research capabilities. The grant will enable the University to create chemically and biologically safe laboratories to support research on AIDS (acquired immune deficiency syndrome) by U-M scientists from the School of Dentistry, College of Pharmacy and Medical School.

"The establishment of biosafety level-three containment laboratories and a state-of-the-art chemical preparations laboratory at the University is critical to contain chemical materials and potentially biohazardous materials associated with the expansion of AIDS-related research at U-M," explained Linda S. Wilson, U-M vice president for research. "We are very pleased that the NIH has recognized the important basic research at U-M on this critical problem through this grant."

Biosafety level-three laboratories, as prescribed by NIH guidelines, are required for work involving "indigenous or exotic agents that may cause serious or potential lethal disease as a result of exposure by inhalation." Researchers working with live human immunodeficiency virus (HIV), which causes AIDS, are required to use biosafety level-three laboratories and procedures, presently unavailable at the U-M.

U-M researchers who will use the new facilities said it is "impossible to overemphasize the importance of the laboratories." They currently must send some of their work to the Southern Research Institute in Birmingham, Ala., for further study.

University officials expect the alteration and renovation of existing space for the new facilities, in the U-M's School of Dentistry, Medical Science Research Building II and C.C. Little Building, will be completed by early 1990.

WSU med students to teach teens about alcohol, drug abuse

In response to concern over increasing drug use in the teen years and even earlier, medical students at Wayne State University are currently taking part in the nation's first program that uses medical students to teach adolescents to resist peer pressure for alcohol and drug use.

Organized by the American Medical Student Association (AMSA) and funded by the Office of Substance Abuse Prevention, US Department of Health and Human Services, AMSA's Substance Abuse Prevention program has trained medical students to provide prevention services to approximately 8,000 adolescents in grades four through eight. Between 150 and 200 students from eight medical schools across the country, including the Wayne State University School of Medicine, have assessed the educational and personal needs of the teens and preteens in their local communities in order to design and conduct effective programs.

AMSA's President, Cindy Osman, MD, noted the high probability that this program will have a profound effect on adolescents across the country. "This idea can work," she said. "We know that children and teenagers are most receptive when they learn from role models whom they respect. Young physicians can be powerful role models and we think they can get to kids before they begin to experiment."

Upon completion of the project, the American Medical Student Association will create educational materials which can be used in the classroom and other community settings for substance abuse prevention education.

Medicare service opens in state

A Medicare information service for subscribing members of the American Academy of Ophthalmology (AAO) is now available in Michigan.

The Medicare Information Clearinghouse (MEDIC) can help ophthalmologists to:

- Decipher Medicare billing issues and guidelines.
- Reduce claim problems and delays due to inaccurate claim submission.
- Understand the correct application of Medicare codes and regulations.
- Monitor the consistency of carrier procedures within each state.

"MEDIC provides subscribers with prompt, current information on Medicare rulings regarding ophthalmic practice," said AA Executive Vice

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President Bruce E. Spivey, MD. "MEDIC consultants are skilled in understanding and deciphering complex carrier interpretations of Medicare regulations."

MEDIC is available to Academy members for an annual subscription rate of $225. The only additional cost is for telephone calls to the MEDIC Hotline (area code 203).

Once enrolled, ophthalmologists and their staffs may place unlimited calls to the MEDIC Hotline to obtain specific carrier information within their states. Questions will be answered immediately, or within one working day if additional research is required.

The service does not include completion of patient claim forms, recommendations or discussion of specific fees for services, techniques to circumvent Medicare rulings, or lobbying and/or advocacy efforts to alter current Medicare policies on either a state or national level. The MEDIC service, which recently completed a four-month pilot program in four states, will be phased in nationally over a 12-month period.

U-M Med Center receives $40,000 grant to study blinding diseases

The University of Michigan Medical Center has been awarded a $40,000 grant from Research to Prevent Blindness (RPB) to support advanced research into the causes, treatment and prevention of blinding diseases.

The award was announced by Paul R. Lichter, MD, chairman of the Department of Ophthalmology, under whose direction the studies are taking place.

RPB awards annual grants to 57 medical schools throughout the nation and is the world's leading voluntary organization in support of eye research. Over the past 29 years, it has made grants and awards to the University of Michigan Medical Center totalling $364,500.

"Through RPB's generous support, investigators at the University's Kellogg Eye Center have been involved in studies encompassing a wide range of problems affecting the eye and vision — from corneal transplantation to glaucoma, from retinal detachment to cataracts," Doctor Lichter said.

WSU, Henry Ford Hospital tackle nursing shortage

Wayne State University is tackling the nursing shortage problem, a growing nationwide concern which a federal commission recently said needs to be addressed by the US Congress. WSU is contracting a partnership with Henry Ford Hospital on two new programs that are aimed at preventing a crippling nursing shortage in Michigan.

Noreen O'Neill, associate dean of undergraduate studies, WSU's College of Nursing, confirmed recently that the arrangement between the 903-bed Detroit hospital and the University has been finalized. The programs, one that educates individuals who have earned degrees outside of the nursing discipline, and another that eases the burden of working students, having to attend school and work, are expected to begin this year.

"This venture is unique. In this Henry Ford/Wayne State University collaboration we are trying to get new people into the nursing world," O'Neill said. "This is a try at meeting the needs of the nursing profession."

In the case of both the Second Career/Second Degree Program, and the Co-op Nursing Education Project, Ford Hospital will cover the tuition expenses of the WSU students. At the end of their academics, the students must either work at Ford Hospital for a specified time period in a salaried position, or they must reimburse the hospital for their education costs. The post-graduate work obligation ranges from 20 months for the Second Career/Second Degree Program, to 40 months for the

Continued on page 11

Physicians in the News

James K. Watkins, MD, a Grand Rapids urologist since 1968, is the new president of the 840-member Kent County Medical Society. Doctor Watkins received his medical degree from the University of Michigan. He interned at Munson Hospital in Traverse City and took his residencies in general surgery and urology at the Cleveland Clinic. In other news, **Paul O. Farr, MD,** a Grand Rapids gastroenterologist and past secretary/treasurer for Kent County, is the new president-elect.

Donald Jacobs, MD, an Iron Mountain physician for 29 years, is the recipient of the first "Upper Peninsula Physician of the Year" award by the Pharmaceutical Travelers Association. To be eligible for the award, a physician's practice must be principally located in the UP.

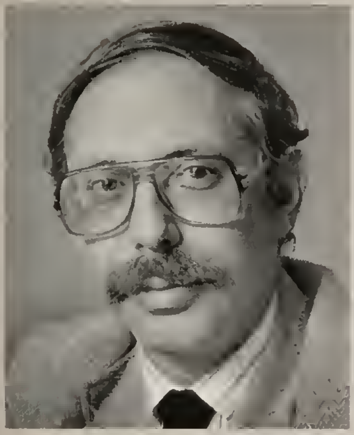
Ali Rahmanian, MD, a Birmingham urologist, is the new chief of staff at St. Mary, Livonia. **Prasad Mikkilineni, MD,** is the hospital's new chief of staff-elect. Both physicians have been on the hospital's admitting staff for seven years.

Dan Doman, MD, is the newly-appointed medical advisor to Allied Health Services of Michigan, a home health care agency. In has advisory capacity, Doctor Doman will guide policies and procedures relevant to patient care.

Norman Krieger, MD, a Milford internist, has been named "Physician of the Year for 1988" by the medical staff at Huron Valley Hospital. Doctor Krieger is chief of staff, Huron Valley Hospital, and is a member of the hospital's planning committee.

Joel R. Saper, MD, director of the Michigan Headache and Neurological Institute was a featured guest on ABC News "The Health Show" in January. Doctor Saper discussed the latest findings in migraine headache research and treatment. "The Health Show" is a 30-minute program that covers breaking news stories as well as trends in medicine, science and general health. The weekly program is aired nationwide to approximately 1.3 million people.

Jeanne M. Lusher, MD, Rochester Hills, is the newly-named Marion I. Barnhart professor of thrombosis-hemostasis research at Wayne State University School of Medicine. Doctor Lusher is professor of pediatrics at Wayne State and is director of the division of hematology-oncology at Children's Hospital of Michigan. This endowed professorship has been established in memory of Marion I. Barnhart, an internationally acclaimed scientist who made many significant contributions to the understanding of blood coagulation, platelet disorders, platelet-vessel wall interactions and stroke.



Robert P. Lisak, MD, a Bloomfield Hills neurologist, is a new member of the Medical Advisory Board of the National Myasthenia Gravis Foundation. Doctor Lisak serves as chief of neurology at Harper and Grace Hospitals and the Detroit Medical Center. Internationally-known for his work on the cause and treatment of Myasthenia Gravis, Doctor Lisak also serves as chairman of the Department of Neurology, Wayne State University School of Medicine.

Douglas B. McKeag, MD, East Lansing, associate professor, director of research and coordinator of sports medicine in the Department of Family Practice, Michigan State University College of Human Medicine, is the only physician who has been appointed to the NCAA Drug Testing Subcommittee. He also has been appointed to the National Board of Medical Examiners and the CBX Case Development Committee.

Roy J. Gerard, MD, professor and chairman of the Department of Family Practice, Michigan State University College of Human Medicine, is the recipient of the College's Outstanding Service Award. The honor recognizes his long-standing support of medical education in the Upper Peninsula, including his support of family medicine and primary care research in the UP.

E. James Potchen, MD, East Lansing, professor and chairperson of radiology, Michigan State University College of Human Medicine, represents the American Medical Association on the Residency Review Committee. His two-year term began January 1, 1989.

Continued from page 10

co-nursing project. O'Neill outlined the programs, explaining that the Second Career/Second Degree Program will take 24 students through 13 months of focused and concentrated instruction in the nursing curriculum. She said that 48 co-op project students will attend classes over ten semesters, or approximately three years, and starting as a freshman will serve one day a week as a nurse's aide at Ford. As the student progresses in their academic studies they will be expected to handle more responsibilities, and eventually will be serving two days a week in a co-op capacity. At the completion of both programs the student is eligible to take the state board's examination to become a registered nurse.

For more information on the WSU program call, (313) 577-4188.

Harper Hospital offers lithotripsy

Lithotripsy, a procedure that uses shock waves through the body to disintegrate kidney stones, is now being used at Harper Hospital. The new system, called the LithoStar, is the first machine of its kind in Michigan.

James B. Smith, MD, PhD, director of lithotripter services at Harper Hospital, says the LithoStar offers certain advantages over lithotripters currently being used at other Michigan Hospitals. "With this system, little or no anesthesia is needed," he says. Additionally, the lithotripters require patients to be immersed into a tub filled with warm water. With lithoStar, patients can lie on the treatment table, and receive the shock waves through a liquid-filled cylinder placed on the side of the body. Little or no pain is felt with the procedure, which takes about an hour and a half.

Lithotripters offers several advantages over previous treatments. It is safer because surgery is eliminated. Recovery time is shorter and it is less expensive than surgery.

Doctors at Harper Hospital expect to treat approximately 10 patients per day. Eventually, patients may be treated for gallstones as well. LithoStar is made by Siemens Medical Systems, Inc.

U-M receives accreditation from ASHA

The Division of Speech/Language Pathology at the University of Michigan Medical Center has received national accreditation from the American Speech/Language and Hearing Association (ASHA).

The division, a part of the U-M Department of Physical Medicine and Rehabilitation, conducts speech/language evaluations, treatment and clinical research at University Hospital and C.S. Mott Children's Hospital. Areas of clinical specialty include communicative disorders following neurological injury and the use of communication assist devices for individuals who cannot speak intelligibly. Last year, the Clinic's eight therapists treated about 1,000 patients.

The program, directed by Elaine Ledwon-Robinson, was recognized by ASHA for its high standards of professional care. Accreditation followed comprehensive review of staff, clinical practices and procedures, records, physical facilities and equipment.

Fewer than 300 of the nation's 2,500 clinics and centers have been accredited to provide speech, language and hearing services, according to Robinson.

Beaumont donates medical equipment to Armenia

William Beaumont Hospital, Royal Oak, recently donated two pieces of medical equipment to the Armenia Earthquake Fund organized by St. John's Armenian Church, Southfield.

The hospital was approached by Armen Shekerjian, MD, who is spearheading the effort locally to send needed medical equipment and supplies to Armenia to help care for the thousands of earthquake victims

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in that country. Beaumont donated a portable X-ray unit and an ultrasound machine to the fund.

Joseph J. Dylag, assistant hospital director at Beaumont, said the hospital was happy to participate in this relief effort. "The earthquake victims needed help and we were able to give them some," he said. "Even though these people are not part of our local community, they are part of our world community and we were glad to be able to participate and help with the relief efforts."

U-M forms rehab research training center

A center to train young physicians to conduct research in physical medicine and rehabilitation has been created at the University of Michigan Medical Center.

The U-M Rehabilitation Research Training Center will allow two physicians to earn master's degrees in clinical research design and statistical analysis from the U-M School of Public Health while conducting research in the Medical School's Department of Physical Medicine and Rehabilitation.

The Center was established with a three-year, $500,000 grant from the National Institute on Disability and Rehabilitation Research. It is one of 11 such centers created across the country since 1986.

Two U-M junior faculty members have been selected to participate in the three-year training program, which began in January.

They are M. David Jackson, MD, and Robert Werner, MD.

Beaumont opens medical facility in West Bloomfield

Services of Beaumont physicians specializing in obstetrics/gynecology, pediatrics, dermatology, orthopedic surgery, and more, will be available through the Beaumont Medical Building, West Bloomfield.

"The building is meant to meet the health care needs of the entire family," said John D. Labriola, vice president, Beaumont Hospital. "Beaumont is the leading provider of hospital inpatient care for West Bloomfield residents. In keeping with a commitment to provide a wide range of services to the community, the Beaumont Medical Building will provide physicians office space closer to the homes of their West Bloomfield patients."

Included in the building is space for custom-designed physician office suites. Beaumont offers diagnostic radiology (X-ray), nuclear medicine and physical therapy services with large private dressing rooms.

An independently-owned pharmacy, open to the public, will be located near the main entrance.

In the building's Community Education Center, Beaumont will offer health education programs such as Lamaze (child birth classes), cardiopulmonary resuscitation (CPR), osteoporosis detection and prevention and smoking cessation, along with classes sponsored by the physicians in the building. Classrooms are also available for civic and community group meetings.

In the spring, a clinic for adolescents with weight and diet-related health problems, operated by Beaumont's Clinics of Preventive and Nutritional Medicine will open.

The 79,000 square-foot facility is wheelchair accessible.

Straith Hospital receives national recognition

Straith Hospital for Special Surgery, Southfield, has received federal designation as an eye surgery hospital. It is one of the only 13 hospitals nationwide — and the only hospital in Michigan — to hold this designation.

Established in 1952 as a plastic surgery hospital, eye surgeries now comprise the majority of Straith's services.

Michigan State Medical Society

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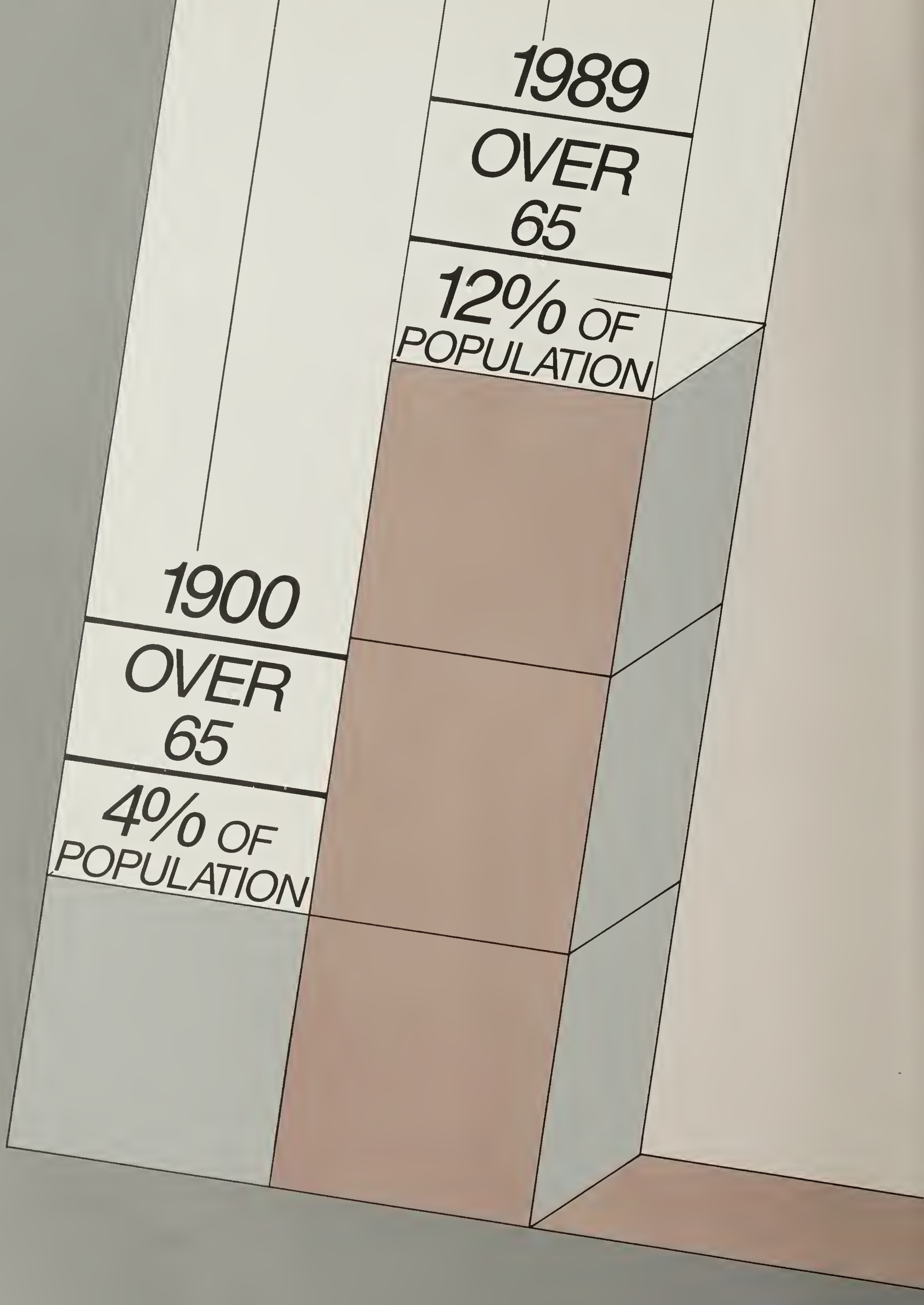

1989
OVER 65
12% OF POPULATION
1900
OVER 65
4% OF POPULATION

HEALTH CARE FOR THE AGING DEMANDS OUR ATTENTION

By James G. O'Brien, MD

Our society will have to concern itself soon with problems of aging. The demographic switch mandates and demands our increasing attention. The percentage of those over 65, which barely numbered four percent in 1900, now exceeds 12 percent of our population, and will continue to increase through the middle of the next century. Currently, Michigan has in excess of one million older adults. Because MSMS recognizes this fact of life, and is paying close attention, the care of the aging is the subject of this month's cover story in Michigan Medicine.

Layers of complexity

Some no longer subscribe to the notion that old age starts at age 65, but think we, more appropriately, should reserve that designation for those over age 75. For it is this group that occupies much of our time as physicians, and poses challenges that stretch our diagnostic and therapeutic acumen. In contrast with middle-aged adults, the elderly are likely to have more than one medical problem and usually a combination of chronic and acute problems that require attention. Typically, the context in which these problems are managed has layers of complexity given the influence of social, economic and ethical factors. For those that are hospitalized, all of the above needs to be addressed in a compressed time frame imposed by DRGs.

It is important to remember that the greatest demands come from a minority (less than 20 percent) of older adults — "the frail elderly" — with only five percent in nursing homes. The vast majority of older adults, even with chronic problems, are fully-independent and living at home without assistance. Many suspect that our elders of the future will be healthier than today's elderly, and given that lifespan is finite, one can expect the period of disability to be less than it is today. An individual today aged 65-69 can expect to live approximately 17 additional years. Unfortunately, only 10 of those years will be fully-independent, according to our estimates, with the remaining seven years having some disability. Only time will tell whether the seven years of morbidity is compressed or extended.

Significant developments

The past year has witnessed developments that will have a significant impact on the practice of medicine, including catastrophic health insurance legislation and Harvard University's Resource-Based Relative Value Scale, which require careful analysis by the Society. The MSMS Committee on Aging wishes to serve the Society in a variety of capacities, including:

1) A resource in the area of aging to all members.

2) Liaison with other groups, including advocacy, service and legislative groups that are involved in providing services to the elderly.

3) An aid in the education of physicians, patients and the public with regard to current issues and developments in geriatric health.

The composition of the Committee is broad-based, with representation from many disciplines and by key individuals who represent the AARP, the Office of Services to the Aging, Michigan Hospital Association, MSMS Auxiliary and medical students.

Many important issues

This past year, the MSMS Committee on Aging has addressed a number of important issues. They include voluntary versus mandatory Medicare assignment, which culminated in the Committee supporting a pilot project in Midland County. (A detailed description of the Midland project appears on page 17.)

A delegation from the Committee will collaborate with the Office of Services to the Aging, the Michigan Nurses Association, the Michigan Pharmacy Association, and members of the pharmaceutical industry to develop a position paper on the Senior Prescription Drug Bill that is currently being considered for legislative action.

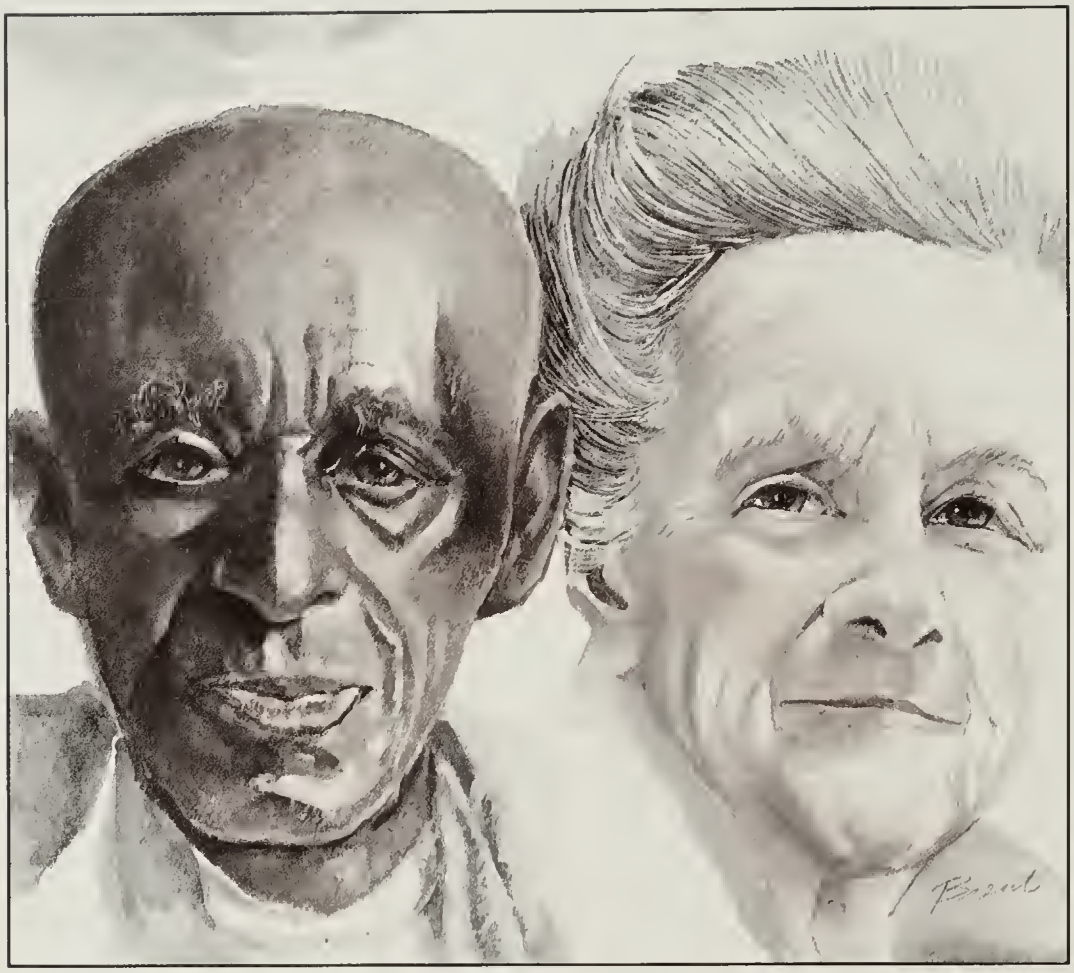
At the MSMS Annual Scientific Meeting in November, the Committee sponsored two afternoon sessions of geriatric programs including "Keeping Older Patients on Their Feet" and "Financing Long-Term Care." The evaluations of both programs were extremely positive.

The Society supported a successful grant proposal to the Administration on Aging to educate physicians regarding the problem of elder abuse. The training will be conducted by Mary C. Sengstock, PhD, of Wayne State University's Department of Sociology, and me, representing Michigan State University. A description and schedule of the training programs appear on page 20.

The MSMS Committee on Aging more recently has sent a representative to serve on the Long-Term Care Advisory Committee of the Michigan Department of Public Health. The Committee members also participated in Senior Power Day and at the Governor's Conference on Aging in Grand Rapids.

It is expected that the MSMS Committee on Aging will continue to be involved in emerging issues that affect the care of older adults and will serve the Society as a resource in this capacity. ■

Doctor O'Brien is chairman of the MSMS Committee on Aging.



AMA's POSITION ON CARING FOR THE NEEDY ELDERLY

Background

The AMA strongly encourages physicians to accept Medicare's approved payment as payment-in-full for needy beneficiaries. Indeed, the physician acceptance rate in the third quarter of last year was 74.6 percent of claims. Three-fourths of the claims were accepted at Medicare's reimbursement level rather than at the private reimbursement level.

Despite this positive evidence of physician responsibility in caring for the needy elderly, several states have introduced legislation that would force physicians to accept Medicare's reimbursement level as payment-in-full. One state, Massachusetts, has made Medicare mandatory assignment for all beneficiaries a condition of licensure for physicians.

Position

The AMA supports a voluntary program for caring for the needy elderly. The Association has assisted medical societies across the nation in launching such programs. They help beneficiaries locate physicians who will accept assignment, and each program is designed to meet local needs and circumstances. The programs build upon community resources already in place.

AMA data indicate that physicians are responding positively. Since 1982, the percentage of physicians caring for Medicare beneficiaries has climbed 30 percent, from 56 percent to 86 percent. Acceptance of assignment of claims increased from 52.8 percent to 74.6 percent during the same period.

Furthermore, it should be noted that not all elderly are needy. Approximately 12 percent of the elderly lived below the poverty level in 1985, compared with 14 percent of the rest of the population.

Thus, the AMA believes it is unnecessary and unfair to require assignment of all Medicare claims. The more affluent elderly clearly can afford to pay the difference between Medicare reimbursement and the full amount charged to private patients.

By Dree H. Lo

MIDLAND COUNTY PROGRAM PROVIDES

ALTERNATIVE TO MANDATORY ASSIGNMENT

Midland, Michigan, an affluent mid-sized community located 30 miles west of Bay City, is probably best known as the home to Dow Chemical Corp. A major employer in the county, Dow Chemical has been headquartered in Midland since its inception in 1897. Not surprisingly, therefore, many of the town's elderly have lived and worked in Midland County all their lives, and have retired there on pensions earned from Dow Chemical or Dow Corning. Others have migrated from the nearby urban centers of Bay City, Saginaw, Flint, and even Detroit, to take advantage of the pastoral setting in their retirement years. It is ironic that although the white-collar city of Midland boasts an average household income of over $43,000, the number of senior citizen households at or below the poverty level is second only to Wayne County.

It is within this dichotomy of income groups that Midland County physicians practice.

Program needed

In the fall of 1987, Robert S. Brown, MD, a general surgeon, recognized the need to identify low-income elderly patients who had difficulty paying their medical bills.

An elderly widow who had been under Doctor Brown's care for some time was delinquent in paying him for care she had received. Doctor Brown was stunned when his patient eventually disclosed, with embarrassment, that she could not afford to pay any medical bills outside of what her insurance would cover. He had known the family, and realized that the woman's financial condition had drastically deteriorated since her husband's death.

It was this encounter which convinced Doctor Brown that there should be a method to identify senior patients needing special financial consideration, and a way to make some sort of assistance available to them locally.

He conferred with the hospital's geriatric specialist, J. Christopher Hough, MD, and together they surveyed the medical staff. There was, indeed, sufficient interest on the part of the staff to help Midland County's needy senior patients; specifically, they would consider accepting Medicare assignment and co-insurance as payment in full for services rendered to low-income senior citizens, foregoing any additional charges.

Doctors Brown and Hough turned next to Sandra Pitts, ACSW, an expert in geriatric social work at Midland Hospital Center. From her program development experience, Ms. Pitts was familiar with community resources which aided the elderly. She suggested the committee work with the Midland County Council on Aging to further develop the concept and to obtain administrative support.

Estelle Weismiller, MPH, executive director of the

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Council on Aging, immediately saw the plan's potential benefit for the senior citizens with whom she worked daily, and organized a focus group of seniors to discuss the idea. Their response was very positive. And so, the Midland County Senior Courtesy Card program was launched.

The program, which has been adopted by most Midland County physicians, is based on a similar state-wide program in Connecticut. Fifteen other states also have programs where physicians accept assignment and co-insurance for Medicare-covered services for the needy. Many were initiated at the county level and became statewide in just a short time. The founders of the Midland program are hopeful that their program will have similar effects in Michigan.

Program objectives

The objectives of the Senior Courtesy Card are simple: to identify the needy elderly discreetly, away from the doctor's office (which prevents any embarrassment on the part of the patient), and to encourage those seniors to see the doctor when necessary without agonizing over out-of-pocket expenses.

"We want to make sure that nobody is forced to decide between putting food on the table or seeing the doctor," Doctor Hough says.

Funding

The first step to getting the program off the ground was funding. Doctors Brown and Hough went first to the staff physicians at Midland Hospital Center where they were subsequently granted $1,000. Presentations to the Midland County Medical Society netted $4,000. After discussions with the Michigan State Medical Society Committee on Health Care for the Aging, the program was awarded $4,000 by the MSMS Board of Directors. Doctors Brown and Hough also requested funding from the Midland Foundation, a local philanthropic organization composed of Midland citizens, which granted an additional $5,000. In total, $14,000 in funds was raised by November 1988.

Eligibility requirements

Working with the Council on Aging, criteria were established for Senior Courtesy Card eligibility. Applicants must:

1.) Be 65 years of age or older.

2.) Live in Midland County.

3.) Participate in Medicare Part B.

4.) Have an annual income of less than $11,600 if single or $15,600 if married (these figures represent 200 percent of the poverty level).

To document eligibility, applicants must present a Medicare card, the previous year's tax return or Society Benefit Statement, and proof of residency (driver's license, voter's registration card, or phone book listing).

Physician participation

Letters outlining the program were sent to all Midland County physicians requesting a formal commitment from each to participate. Doctors Brown, Hough, and several other staunch supporters had lobbied hard for the program at previous county medical society meetings, and their diligence has paid off. Nearly 100 percent of the doctors providing care to senior citizens agreed to participate in the Senior Courtesy Card program.

Program promotion

Getting the word out to eligible patients and participating physicians was the next step toward implementation. The program retained an advertising consultant to produce an informational brochure and publicity poster. The poster, which briefly explains the program and encourages those who are eligible to sign up, was provided to participating physicians along with a window decal which identifies them as program participants.

A letter was also sent to all office staffs which described the program, provided staff personnel with answers to questions patients might ask, and Medicare billing concerns.

Lastly, a wallet-sized identification card was designed for enrolled seniors to present to their doctor's receptionist identifying them as Senior Courtesy Card members.

Enrollment drives

The Council on Aging estimates that 4,000 people in Midland County fall within the "elderly poor" guidelines. The Council recommended enrolling those eligible in a step-by-step fashion so as not to be deluged by interested seniors. By late October 1988, the printed material was ready for distribution, and Council social workers seeing homebound seniors signed up those who qualified. Homebound registration took approximately one month.

In November, enrollment drives began at senior housing complexes and meal sites throughout Midland County. Publicity posters were hung with notices marking the dates and times of Senior Courtesy Card presentations. The Council had a designated speaker who travelled to each site, giving the presentation and signing up qualified seniors on the spot. To help defray costs, a one dollar donation from each enrollee was accepted.

Early feedback

Now three months into the program, all indications from patients and physicians are positive. Only two questions on Medicare billing have been brought forth by doctors' offices. The few seniors who have called the Council on Aging with billing questions have been directed back to their physician's billing clerk.

Program evaluation

Enrollment drives have not produced as many registered seniors as originally projected. Currently, the program has signed up 650 seniors, 15 percent of the estimated needy elderly in the county. Possible explanations for the low turnout include:

- Seniors are waiting to sign up for the Card until they go to the doctor.
- Some doctors already forego out-of-pocket payment.
- People have not heard about the program.
- The original estimate of eligible seniors was inaccurate.

It was hoped area newspapers and television stations would cover the story from a public interest angle. So far, the local *Midland Daily News* and the Council on Aging's *Senior Power* have run articles. The committee has since drawn up a publicity plan which includes these options: public service announcements on area television and radio; enlisting the help of local clergy; asking the Department of Social Services to assist in enrolling their qualified elderly; and photo opportunities with Congressman Bill Schuette and the first senior who signed up for the program.

Information available

Midland's Senior Courtesy Card Program planning committee stands ready to discuss their model program with any interested group, and to assist other counties in setting up their own program. For information, contact the Midland County Council on Aging, 1208 James Savage Rd., Midland, MI 48640 (517) 835-3041. ■

The author is a Midland-based freelance writer.

By Samuel M. McMahon, MD

LONG-TERM CARE STILL A PROBLEM

AFTER CATASTROPHIC HEALTH CARE BILL

Ten years or so ago, I cared for a very pleasant 62-year-old lady who had the misfortune to fall and fracture her cervical spine, with consequent quadriplegia. Because of respiratory complications, she was unable to leave the hospital for about a year-and-a-half before finally succumbing to complications of her illness. It was a particularly sad case not only for her, but for her husband who was impoverished by her illness, and also for the hospital and community which were obliged to pay for a considerable amount of uncovered care.

Catastrophic illness and the need for long-term care are potential problems for all of us. Anyone can be afflicted by cancer or diseases such as rheumatoid arthritis, alzheimer's disease, or paralysis. No one can afford the costs of these kinds of illnesses. Older citizens, in particular, worry about the costs of these catastrophic illnesses and the possibility that their spouse or remaining family may be impoverished by them.

Physicians should have special concerns about long-term care because of our pivotal roles in health care and the readiness of others to blame us if costs are too high or if a family is impoverished. Someone has to be concerned about the plight of sick people in need — the children, the poor, single parent families and others — and if we who have seen these people and know them do not advocate for their care, it is hard to know who will. In addition, a physician in private practice should have special concerns about his or her own possible need for long-term care. Where there is no employer to cover an illness, when there are no earnings and costs are high, a physician is especially vulnerable to catastrophic illness — unless he or she has had the foresight to obtain a good disability policy.

A real need for long-term care

There is a real need for long-term care in America. We have an aging population such that those above 80 years of age are currently the fastest growing segment of our population. There is a constant, or even increased, expectation of us as providers from patients and others, and there is also the issue of the rising costs of health care which none of us have been able to control.

It is estimated that only five percent of elderly Americans are in nursing homes, but there is an estimated cost of over $50 billion per year for these

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elderly. The cost for this five percent is expected to rise up to perhaps $90 billion per year in the mid 1990s. But, for every elderly person with a chronic illness in a skilled nursing facility, there are two others who are equally ill and being cared for in the home by family members.

The cost to society for those treated in the home is fairly minimal in comparison to the very high cost of those in nursing homes. There is still a cost to be paid for those treated in the home, and that cost is mostly paid in terms of self denial, self health, and expenditure of economic resources by the home caregiver.

The Medicare Catastrophic Coverage Act of 1988 (Catastrophic Care Act), was passed to provide some relief for older persons who are victims of a serious illness. It has been welcomed by many of us who are concerned about impoverishment of older citizens with serious illnesses.

The new act decreases the hospital deductible per year for each beneficiary to just one admission, with no requirement for hospital co-insurance. Skilled nursing facility days were increased from 100 to 150 days per year. It will, over a three-year period of implementation, limit the out-of-pocket beneficiary costs, pay for some IV drugs and immunosuppressives, and expand the benefits for home health care, hospice care, mammograms and respite care. In addition, it increases Medicaid coverage for certain impoverished elderly and disabled persons, as well as increasing access to Medicaid for impoverished women and children. It also limits, to some extent, the impoverishment of a spouse when the patient is attempting to qualify for Medicaid.

The Catastrophic Care Act has been severely criticized by some older citizens who now realize they will be paying for the increased benefits through higher taxes. The enhanced benefits of the act will be paid for by the same elderly citizens who will enjoy most of the benefits. Since these increased taxes have been based upon a preliminary estimate of the costs involved, the taxes ultimately required may be a good deal higher than those proposed.

Medicare Act inadequate

The real problem with the Catastrophic Care Act is that long-term care has still not been addressed adequately. Although elderly persons in skilled nursing facilities and hospitals have increased benefits, there is no coverage at all for younger persons who are neither insured nor eligible for Medicare. These younger persons may have equally severe and catastrophic illnesses. No aid is provided for the families who will be giving care for those people at home, and who may impoverish themselves to provide the required care for their loved ones.

There is very little relief for the majority of disabled elderly who are kept at home, or for their family caregivers who deplete their health and their resources to provide the required care. A very real possibility is that some of these elderly treated at home will move to skilled nursing facilities in the future, leading to a very dramatic increase in the cost for the Catastrophic Care Act. By inference, dramatic increases in taxes for the elderly could result.

The needs of home caregivers have been largely ignored in the Catastrophic Coverage Act. If we are "saving" somewhere between $100 billion and $300 billion per year by hoping the home caregivers will continue their services, then why have we ignored the needs of these home caregivers?

The Act allows for 80 hours per year of relief for home caregivers, but makes no provision for home caregivers to get access to community services which might help them. Examples would include: "Meals on Wheels"; voluntary respite organizations; legal help; and various local health services in the community which home caregivers may not use or understand. There is no recognition of the hours of effort by home caregivers or their special needs for advice and for physical help.

It appears to me that the Catastrophic Care Act, though it is very worthwhile in many respects, has missed the mark in addressing the needs of patients who require long-term care. Still needed is coverage for patients with catastrophic illnesses who have neither insurance nor Medicare coverage. Some relief must be found for those elderly who are receiving long-term care at home and especially for their home caregivers who are carrying most of the burden of long-term care in the elderly. ■

Doctor McMahon is Vice President of Medical Affairs, Ingham Medical Center, Lansing.

Programs on Elder Abuse Planned

MSMS is cooperating in a joint project, funded by the Administration on Aging, US Department of Health and Human Services, to develop and provide training to Michigan physicians on elder abuse. MSMS is one of several co-sponsores of the project; others include the Michigan State Office on Aging, the Michigan State University College of Human Medicine, and Wayne State University, which is administering the project.

St. Lawrence Hospital Geriatric Assessment Center, Lansing, will provide access to case materials on abuse and neglect, and two techniques for distinguishing abuse/neglect from other problems of aged patients.

Co-principal investigators are Mary Sengstock, PhD, Department of Sociology, Wayne State University, and James G. O'Brien, MD, MSU College of Human Medicine, and chairman, MSMS Committee on Aging.

Four day-long training programs will be held at four sites strategically located to serve physicians in all regions of the state. Specific times and locations will be announced in a future issue of Michigan Medicine *and* Medigram.

The programs will be targeted toward primary care physicians, including family practitioners and internists, and certain specialty groups, such as orthopedic surgeons and emergency care physicians.

Each program will address a variety of issues: definition and description of types of abuse and neglect; legal dimensions, including Michigan's mandatory reporting law; techniques for interviewing and obtaining case histories; distinguishing symptoms of abuse from normal signs of aging; and referral needs.

Staff for the training programs will include: James G. O'Brien, MD; Brooker Masters, MD, member, MSMS Committee on Aging; and Paul Werner, MD, Department of Family Medicine, Wayne State University. ■

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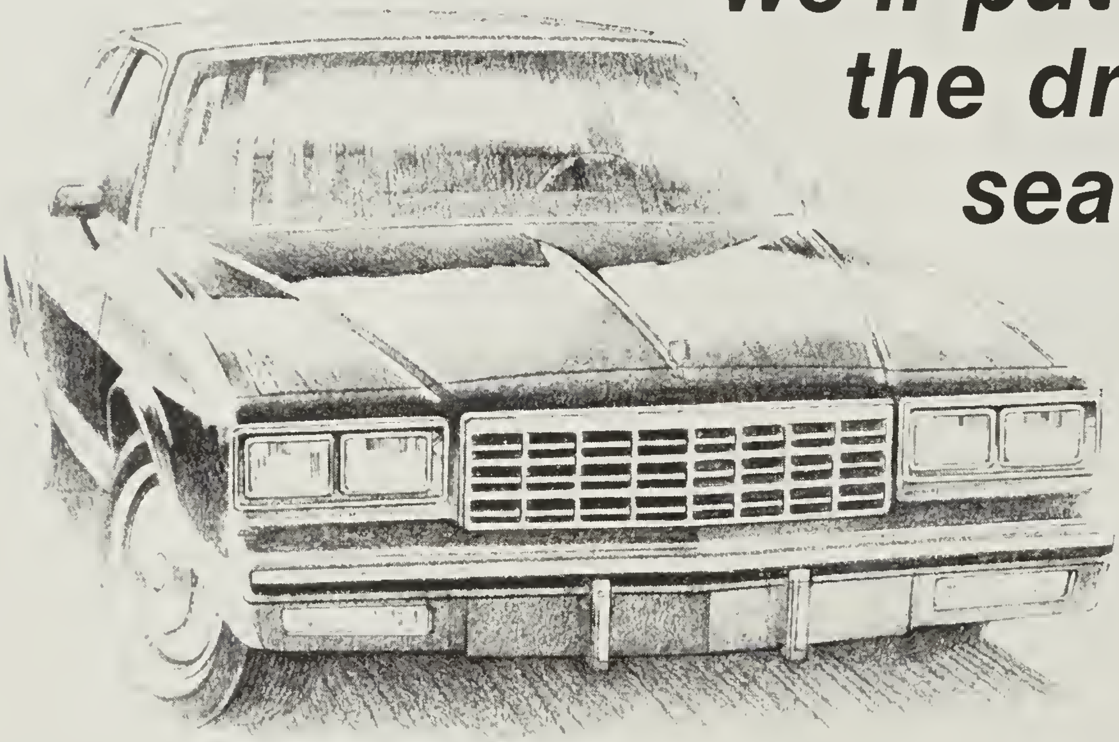

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Rep. Patrick Gagliardi
A Fighter for Rural Physicians

By Chad B. Munger

"I don't know how one can get around the suit-happy society we live in, but tort reform is at least part of the answer."

A "political transplant" is one way to think of 38-year-old Rep. Patrick Gagliardi (D-Drummund Island). Born in Bay City and raised in Midland, Rep. Gagliardi was endeared to northern Michigan 20 years ago as a Lake Superior State College student. It was an area he liked so well, he never left.

The relationship this man has developed with his six-county district, which extends from Petoskey to Escanaba, has made him a very popular man. His interest in the people of his district and in his home is reflected by what he says is his greatest concern as a representative — being a source of concrete help to those in his district.

"Trying to handle constituent problems is one of the most challenging parts of being a legislator," he says, "but helping people cut through the red tape of government is an important part of this job."

The popularity he enjoys at home has followed this fourth term representative to Lansing. For the coming term his party caucus has elected him to replace Lewis N. Dodak as majority floor leader in the House. The self-described "country bumpkin" from the U. P. defeated several senior legislators for this prestigious position.

"Keeping up with the dynamics of a group of 148 bright and politically-experienced people is always a challenge," he says, "but it makes the job a very satisfying one."

Short-term plans

This term, the floor leader will be "keeping up" with budget concerns and the re-election pressures of 1990.

"The real difficulty of the budget this year will be trying to meet the dramatically increasing demand for services," Rep. Gagliardi says. "We're talking about the demand for services that equate directly into dollars. I take great pride in the fact that, in the last five years, we have not spent more money than we have taken in. We've got the state back on stable financial ground."

No deficit spending is the positive side of what is going on with the budget, Rep. Gagliardi explains. The difficult aspect of it is deciding which groups will have to survive without the extra allocations.

Corrections and K-12 education have dominated the state budget for the past six years and will likely continue to do so, Rep. Gagliardi predicts. "There is a push to build more prisons and end the early release programs of the seventies and early eighties," he says. "And because we didn't come up with any answers to the refinancing of our educational system last year, it will be a big issue again with the public and in the capitol."

The pressure of election year will also be in the back of his mind this year. "I think that 1990 is on everyone's mind around here, everybody is up for re-election and the election cycle has already started here at the capitol," he says.

Rural health concerns

Health care, in Rep. Gagliardi's district, faces a number of difficulties because of its rural setting, chief among them is keeping physicians in the area.

A great concern to Rep. Gagliardi is losing a physician's services because of what he feels are disproportionately high malpractice insurance premiums. "Physicians in a rural area, where chances of being sued are lesser and chances of a smaller settlement are greater, still pay the same rates as physicians in the city who are at greater risk for both a suit and a large settlement.

"I don't know how one can get around the suit-happy society we live in, but tort reform is at least part of the answer."

Rep. Gagliardi points to past legislative actions to reduce the statute of limitations on medical malpractice suits as a positive step. "You are not going to take away a person's right to sue, so instead you must limit them in some way. I think the Fleming fund will be revisited, with a real look at protecting doctors assets."

A look at his district

Rep. Gagliardi does not see the physicians of his district as an exceptionally active political group. He explains that their being in a rural location keeps them exceptionally busy professionally. "I think the most important thing is for a person to exercise his/her right to vote, and I think that the professional people in my district are very conscientious of that. Hospitals and physicians do contact me and I try to meet with them whenever they request."

About his political future, the Representative is quiet. "I don't have any secret plan in my head about being a senator, a congressman or the governor. I just want to do a good job at being a legislator and now my caucus has given me a very nice opportunity to serve as majority floor leader." ■

The author is an East Lansing-based freelance writer.

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"Break the Silence"

Campaign Continues to Gain Momentum

The "Break the Silence" campaign to increase the public's awareness of the desperate need for organ and tissue donation continues to gain momentum as more groups become involved.

The campaign, which started in October as a joint project of the Michigan State Medical Society, the State Bar of Michigan and the Michigan Hospital Association, has branched out to the local level. The Wayne County Medical Society and the Detroit Bar are making plans to promote the campaign as are the Ingham County Medical Society and the Ingham County Bar. In Genesee County, the Medical Society and the Genesee County Bar established a permanent liaison committee as a result of the campaign.

Seven outdoor advertising companies across the state have donated a total of 92 free "Break the Silence" billboards as shown above. These billboards are showing up all across Michigan. The outdoor advertising firms include Dingeman Advertising in Muskegon, Adams Outdoor Advertising of Kalamazoo, Gannett Outdoor of Detroit, Adams Outdoor of Lansing, Gannett Outdoor of Grand Rapids, Dingeman Outdoor of Traverse City and Gannett Outdoor of Flint.

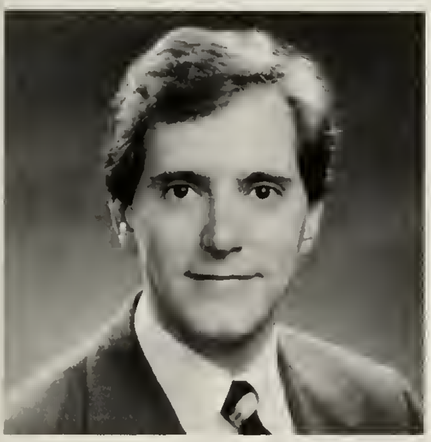
In February, the "Break the Silence" campaign won an Award of Achievement from the Central Michigan Chapter of the Public Relations Society of America. The campaign will now go into the national public relations competition.

During the National Organ and Tissue Donor Awareness Week, April 23- 29, Secretary of State Richard Austin has agreed to place "Break the Silence" brochures in every Secretary of State office in Michigan.

County medical societies are urged to contact county bars and local hospitals to help promote the "Break the Silence" campaign. Those wishing to do so may call David Fox, Chief, Media Relations, at MSMS for contact names and promotional ideas. ■

Meet Michigan's New Lawmakers

Ten individuals were newly-elected to the Michigan legislature last fall. So that our membership might become more familiar with these new public servants, MSMS contacted each of them and asked for biographical information and a response to this question: What is the legislature's role in promoting the availability of quality health care services in Michigan while at the same time emphasizing the need to contain health care costs? Eight lawmakers responded to our request.



Rep. David L. Camp (R-102) Midland

Background: Attorney, Riecker, George, Van Dam & Camp, P.C., since 1978. He served as administrative assistant to Congressman Bill Schuette (R-East Lansing), from 1984 to 1987; campaign manager, Bill Schuette for Congress 1986; and as special assistant to the Attorney General from 1980 to 1984. He is a member of the 10th District Republican Executive Committee; Midland County Republican Executive Committee; former precinct delegate; and a former member of the Midland County Board of Canvassers. He received the "Outstanding Young Men of America Award" in 1981 and again in 1983.

On health care: "The legislature is the public body where much of the debate over the availability of affordable health care in Michigan takes place. The legislature's role is critical in reflecting society's priorities regarding health care.

Availability and access to health care as well as cost containment are the parameters of the legislature's discussion. "This is a particularly challenging time period for assuring quality health care at an affordable cost. The cost of long term care, AIDS, the medical problems of an aging population, and transplantation technology are all straining the medical resources of our state and will intensify the health care debate in the state House."

Rep. Nancy Crandall (R-97) Muskegon

Background: Received a BSN degree in nursing from the Indiana University School of Nursing in 1961. She has worked as a nurse at George Ade Hospital, Obstetrics Department, Brook, Indiana, and at University Hospital, Pediatrics Department, Ann Arbor. She has served as a psychiatric nursing instructor at Mercywood Hospital, Ann Arbor. Her voluntary activities include: past president, MSMS Auxiliary; past president, Muskegon County Medical Society Auxiliary; delegate, AMA Auxiliary, Legislative Committee. In a political capacity, she has served on the Norton Shores City Council and the West Michigan Shoreline Regional Development Commission. She is currently a member of the Muskegon County Republican Party Executive Committee and the Michigan Export Development Authority.

On health care: "The legislature should assist those segments of the Michigan population who do not have access to quality health care; the poor and uninsured. At the same time, we need to work with the professions to slow the escalation of health care costs while mandating access and quality of care. State risk pools for the uninsured, tort reform and relief of liability costs, joint efforts in quality assessment, and quality assurance programs would be specific areas to address.

"I will be co-chairing, with Rep. Michael Nye, a House Republican Task Force on Health Care for the Uninsured. We will be gathering background information from the professional arena and will be holding public hearings around the state. We hope to make positive, informed recommendations to the legislature regarding affordable health care for the uninsured citizens of Michigan."

Jan C. Dolan (R-69) Farmington Hills

Background: Served on the Farmington Hills City Council from 1975 through 1988, with two terms as Mayor. She is a member of the Board of Trustees of the Community Center of Farmington-/Farmington Hills, Botsford General Hospital and Farmington Area YMCA. The owner of Adult Day Care Center, she is active in the following organizations: American Association of University Women, Farmington Area Chamber of Commerce, West Bloomfield/Farmington League of Women Voters, Rotary International, Professional Women's Network, Farmington Families in Action-Advisory Board and AARP.

On health care: "As a 'freshman' representative, I do not know how the legislature can best approach these growing problems. I believe we must address access to health care for that segment of the population with little or no health care services; assure continued availability of services in rural and urban centers, while working within the budget constraints.

"The legislature should establish *realistic* goals and objectives. A healthy Michigan population translates into a productive Michigan population and should be the primary goal of us all."

Continued on page 26

Terry London
(R-76) Marysville

Background: First elected to the Michigan House of Representatives in 1984, he was defeated in 1986, and was re-elected to a second term in November 1988. Prior to his election to the legislature, he served as a customer representative for Detroit Edison Company. He is former chairman of the St. Clair Community Republican Party.

On health care: "The legislature has an appropriate role in promoting availability of quality health care that is cost effective. The legislature's role in the delivery of health care in Michigan centers on three questions: 1) Who will receive health care treatment?; 2) Who will pay for the treatment?; and 3) Who will perform the treatment?

"These are societal questions that legislators are elected to answer. Often they are political questions which are discussed with an eye toward increasing access to health care while making care affordable. The state legislature is a major forum where these questions are discussed and hopefully resolved."

Gregory E. Pitoniak
(D-29) Taylor

Background: Received his bachelor's degree in urban studies and political science from the University of Michigan in 1976, a master's degree in public administration from the University of North Carolina in 1980, and attained Certified Industrial Developer Accreditation from the American Economic Development Council in 1984. He is past director of Economic Development for the Downriver Community Conference and past executive director of Economic Development Corporation of Wayne County. He was appointed by Governor Blanchard to the State Community Development Block Grant Advisory Board from 1984 to 1989; was elected as Taylor City Council chairman for the second time in 1987; is a member and past chairman of the Community and Economic Development Advisory Committee, and a member of the Southeast Michigan Council of Government. He served as president of the Michigan Young Democrats from 1982 to 1984; regional vice president of the Michigan Industrial Developers Association from 1987 to 1988; and is a former member of the Taylor Planning Commission and Wayne County Private Industry Corporation Board of Directors. He received "Outstanding Young Person Award" from the Taylor Jaycees in 1987.

On health care: "As a new state legislator, with a limited background on health care issues, I have not had the opportunity to appropriately consider the legislature's role in this major public policy area. Nevertheless, I believe we have a serious responsibility to assure that basic health care services are available to all Michigan citizens, regardless of financial means. I believe we should encourage and support programs which promote preventive health care efforts by individuals. Furthermore, I believe the legislature must encourage and support efforts and practices which minimize the complexity and costs of health care service delivery while maximizing the benefits and quality of such services."

Kirk A. Profit
(D-22) Ypsilanti

Background: Obtained his Doctor of Laws degree from the University of Detroit, become legal advisor to the Washtenaw County Sheriff's Department, then served as Undersheriff for Washtenaw County. He has served as assistant executive majority director for the Michigan House under former Speaker of the House Gary Owen.

On health care: "The legislature has a role in helping to control health care costs by increasing opportunities for competition among certain services and providers, by insuring access to health care, and by paying a fair price for the services the state purchases. It also has an obligation to assure that certain people who need assistance can obtain health care services through such programs as Medicaid.

"As a health care cost-containment measure, increasing competition by promoting alternative health care delivery systems has received major attention. In addition to promoting health care maintenance organizations (HMOs), the state has supported prudent purchaser agreements (PPAs). PPAs allow insurers and other third-party administrators to enter into agreements with health care providers and facilities for the provision of specific health care services.

"Another cost-containment measure has been the establishment of the Certificate of Need (CON) program. The CON process is a major state regulatory program aimed at controlling health care costs associated with the construction, renovation, and modernization of health care facilities, the purchase and replacement of major medical equipment, and planning and controlling the development of health care services so as to prevent duplication and unnecessary utilization. In 1988, the legislature completed a major revision of this program which should insure a more viable CON program.

"In addition, the Governor directed the appointment of a State Government Health Care Delivery and Cost Containment Team to work with business and labor to set a new agenda for reducing health care costs. The Economic Alliance has made this issue its first priority and the legislature will be studying its recommendations.

"The Governor recommended initiatives to limit the growth of the Medicaid budget in the 1988 budget, and while many of those recommendations were not adopted, it is anticipated that further initiatives will be considered this year.

"As a means of dealing with the availability of health care services, the Governor's Task Force on Access to Health Care will also be making recommendations this year on what the state and private businesses can do to insure access for those who do not meet the criteria for state assistance nor have access to private health insurance. These recommendations will deal with the availability of health care services in Michigan.

"Hopefully, these proposals will enable Michigan to control rising health care costs in the future and improve access to quality health care. Unfortunately, many proposals also need to be addressed by the federal government and third-party payors as well as by the Michigan legislature."

William J. Runco
(R-31) Dearborn

Background: A 1981 graduate of the University of Michigan School of Law, he is currently a partner with Runco, Tyler & Xuereb, a general civil practice with an emphasis on business organization, acquisition and disposition; real estate transactions; personal injury; and litigation. From 1983 to 1987, he served as state representative for the 31st District; minority whip (1983-1985); vice chairman, Senior Citizens & Retirement Committee; and a member of the following committees: Judiciary, House Policy, State Affairs, and Colleges & University. Prior to that, he served as Wayne County Commissioner and member of the following committees within the 22nd District: Ways and Means, Human Resources, Rules, and General Government.

On health care: "The liability crisis has forced the medical community to take measures that were previously not called for such as requesting extra tests, second opinions and referrals, and extra indepth documentation of treatment, which has driven costs up. It is time that the legislature reached an agreement on how to resolve this crisis within the next two years.

"We have a duty to pass responsible legislation which would contain costs. One way would be to make sure that health care is given by licensed and regulated caregivers. Adequate funds should be appropriated to provide quality pre- and post-natal care. No legislation should be passed along the lines of mandatory assignment which does not provide a means test for balancing medical payments according to need."

Bart T. Stupak
(D-109) Menominee

Background: An attorney, he served as a partner with Stupak, Bergman, Stupak, P.C., from 1985 to 1988. Prior to that, he served as an attorney with Hansley, Neiman, Peterson, Beauchamp, Stupak & Bergman, P.C. from 1984 to 1985. For 11 years prior to becoming an attorney, he served as a trooper with the Michigan Department of State Police. He earned his law degree in 1981 from Thomas J. Cooley Law School, Lansing.

On health care: "Hospital care expenditures claim the largest share of the health care dollars, approximately 39 percent. Physician services account for approximately 19 percent. Michigan employers currently pay more for employee health plans than they do for combined expenses of unemployment insurance, worker's compensation, and the single business tax. In 1986 alone, employers spent more than six billion dollars on health care costs which represented a 10.7 percent increase over 1985. In actual dollars, this amounts to about $2,046 per employee.

"As far as cost-containment strategies, Michigan has been trying to increase competition by promoting alternative health care delivery systems. In addition to promoting health maintenance organizations, the state has provided prudent purchaser agreements. These prudent purchaser agreements would allow insurers and other third party administrators to enter into agreements with health care providers and facilities that will provide specific health care services.

"More creative ways to try to stem the rising costs of health care can and must be addressed by the legislature. It appears that the problem does not lie necessarily with the physician, but with the hospital rates and the cost of prescription drugs." ■

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AMA Meeting

Addresses State Health Concerns

By Mitchell A. Rinek, MD

Members of the Michigan delegation to the AMA journeyed to Florida in January to attend the annual AMA State Health Legislation Meeting — a truly outstanding event.

The MSMS delegation was composed of Fred W. Bryant, MD, MSMS president; Robert E. Paxton, MD, MSMS president-elect; Robert D. Burton, MD, speaker of the House; Marguerite Shearer, MD, chairman, Legislative Policy Committee; Peter A. Duhamel, MD, MDPAC chairman, Kevin Kelly, MSMS assistant director; Terry Vanderveen, manager, MSMS Department of Government Relations; and myself, chairman, MSMS Committee on State Legislation and Regulations.

Physicians and staff from all 50 states and many specialty societies attended the meeting. In addition, Michigan State Senator William A. Sederburg was a speaker at the meeting. The senator, who is a computer expert, used his portable computer and a set of cleverly prepared slides to illustrate to the audience the differences in thought patterns and consensus arrangements between physicians and legislators. The audience was left with a full appreciation of the legislative priorities of compromise and how legislators reach a decision.

In the next few paragraphs I will try to describe some of the ideas and issues touched upon at the conference. Some are simply a review of the issues heard in the past and will likely plague medicine for many more years such as mandatory assignment and medical liability. Others were somewhat unique. For instance, we learned about a state medical society which had involved itself in a statewide tort reform initiative and in the election of state Supreme Court Justices.

We heard from several of the AMA "brass," including James E. Davis, MD, president of the AMA, who gave the welcoming address, and P. John Seward, MD, chairman of the AMA Council on Legislation.

United States Senator Dave Durenberger (R-Minnesota) gave the keynote address. He discussed the importance of AMPAC and its contributions to his recent senatorial election, the upcoming budget battles in Washington, D.C., including the annual potshots at physician reimbursement, and the ethical and moral implications that budget shortfalls mean to access to care. He also reminded us that future cost containment ideas will include prospective fees and not fees for service, expenditure targets and expenditure caps.

RCTs

James H. Sammons, MD, AMA executive vice president, spoke very specifically about the AMA proposal dealing with Registered Care Technologists (RCTs). This issue has prompted tremendous discussion with many advocates on both sides of the fence. Doctor Sammons was very direct in his remarks, often criticizing the various nursing organizations that had opposed the AMA RCT proposal. He emphasized that the RCT proposal only called for a "pilot project" and that it was designed to provide patients with quality care by addressing the nursing shortage of bed-side care givers.

Anti-trust exemptions

We heard attorneys from the Oregon Medical Association, the California Medical Association and the AMA discuss the various legislative opportunities to comply with federal anti-trust exemptions, and several reactions following the Patrick decision. (I should note here, however, that MSMS attorney Richard D. Weber has told MSMS that the state anti-trust exemptions in its peer review law have not been threatened by the Patrick case.)

"Mandatory insurance" laws

Massachusetts State Senator Patricia McGovern and Hawaii Medical Association Assistant Executive Director Becky Kendro described their respective "mandatory insurance" laws. The Hawaii law was only designed to provide coverage to 50,000 people, while the Massachusetts problem was more than 600,000 people, mostly women and working poor. The Massachusetts problem is exacerbated by an expected budget shortfall that may jeopardize the program. Senator McGovern also pointed out that Massachusetts hospitals were reimbursed by the state more than one-third of a billion dollars each year for providing free bed and emergency care. It was hoped that this fund, which is being reduced because employers are providing insurance, could be eliminated.

Ethics

There was an excellent discussion regarding conflict of interest in medicine and the ethics surrounding it. The key point in this discussion centered on the point that full disclosure of potential conflict of interest by a physician does not fully absolve that physician or facility from legal problems.

AIDS

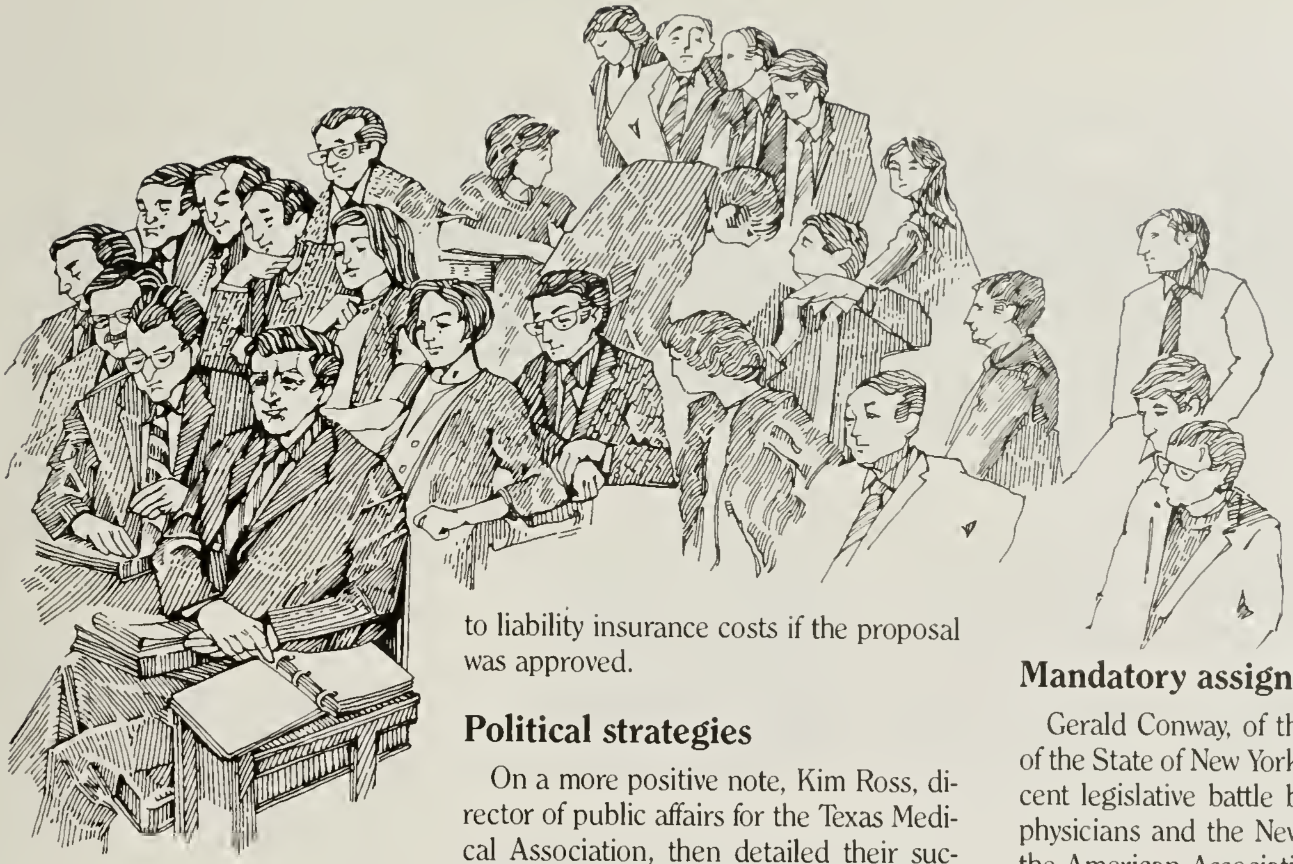
The presentation on AIDS included an overview of individual states' responses to AIDS, by Richard Merritt, director of the Intergovernmental Health Policy Project, and a "street primer" on the problems of AIDS in the substance abuse population of America. Beny Primm, MD, executive director of the Addiction Research & Treatment Corporation in Brooklyn, New York, brought the attendees back to the streets. He asked them to expand their horizons beyond alcohol and tobacco and look to assist the fight against other substances (crack) and substance abusers. He also discussed the plan offered by a Presidential Commission on AIDS.

Tort reform

The final topic was a forum on tort reform and a specific discussion of four states – Oklahoma, Wyoming, Kansas and Texas – and their attempts to pass tort reform and the following constitutional challenges. We learned that any legislative attempts to improve professional liability laws should include a very detailed legislative history and legislative purpose, both of which are very important when these law changes are challenged in the courts. It was also suggested that data detailing a health care crisis and the need for legislative change should also be part of the record.

Non-economic damage

Donald C. Jones, executive vice president of the Florida Medical Association



(FMA), gave an excellent presentation on the experience of his association in its recent attempt to place a $100,000 cap on non-economic damage recovery in the Florida Constitution. This initiative attempt, which failed by a 56-43 percentage margin, appeared to have a number of problems. Those included:

- Great expense in collecting the required number of signatures to get on the ballot.
- Limited financial backing from non-medical groups. Of the $7.8 million raised, doctors (71 percent), hospitals (13 percent), and medical groups and insurance companies (10 percent) raised more than 95 percent. That lack of support from the public insurance companies, businesses and business organizations and drug manufacturers spelled doom.
- No editorial support. Only one newspaper, a Spanish newspaper in a Republican area, supported the ballot initiative.
- Very negative ad campaign by the Florida Trial Lawyers Association. Jones showed the television ads that ran, and they were amazing. The campaign from the trial bar told the public that this ballot proposal would place a limit of $100,000 recovery from drug dealers, drunk drivers and toxic waste polluters. It also told that insurance companies would suffer. This aspect was even more damaging because the television stations would not let the FMA answer the drug dealer, drunk driver, toxic waste polluter campaign. In addition, the non-physician insurance companies would not estimate any cost savings to liability insurance costs if the proposal was approved.

Political strategies

On a more positive note, Kim Ross, director of public affairs for the Texas Medical Association, then detailed their successful campaign to change the make-up of the Texas Supreme Court. In his presentation, which also included television ads, he made several suggestions that should be in any political strategy. Those were:

- Do not pit the physicians against the lawyers; instead position the physicians as the underdogs.
- Be sure to politicize the Supreme Court or whatever race you are trying to influence.
- Convince your allies to come on board early.
- Convince your candidates to be tough, and, if necessary, nasty.

Medical waste tracking laws

A representative from the American Dental Association discussed the recent federal medical waste tracking law and its possible effects on individual state tracking laws. She gave a very interesting presentation, especially for those of us from states with recent and future discussions on this issue. Her main suggestions as to what should be included in a state law were:

- Delegate the tracking authority to a state health agency, not a licensing agency.
- Work to keep the definition of infectious waste simple.
- Allow office treatment of the infectious waste.
- Allow normal disposal of sharps.
- Oppose "cradle to grave" liability; instead create immunity for physicians if they dispose of the waste properly.
- Support a "small generator" exemption. (This sounded a little self-serving.)

Mandatory assignment

Gerald Conway, of the Medical Society of the State of New York, discussed the recent legislative battle between New York physicians and the New York Chapter of the American Association of Retired Person regarding mandatory assignment legislation. Of major importance was the fact that AARP has targeted this issue as a "top priority." Mr Conway suggested that those physicians eligible to join AARP should do so, to the point of becoming active in the association. He made several other suggestions including:

- Do not necessarily be nice to the seniors; instead treat them as you would any other lobbying adversary.
- Discuss the increases in all government spending for seniors, as compared to children and other poverty groups and programs.
- Discuss the facts behind the return of Social Security payments, income tax credits, etc., to the seniors, especially when they speak of Medicare as an entitlement program.
- Develop a voluntary assignment program, with a "means test."
- Discuss the problems of access, using Massachusetts as an example.
- Discuss, continually, the use of a means test even in the mandatory assignment fight.
- Show examples of how this could mean health care rationing.

All in all, the AMA Conference on State Legislation provided an excellent opportunity for Michigan physicians and staff to interact with representatives from other states. If you have any questions regarding the meeting, please feel free to contact me or any other member of the Michigan Delegation who attended the meeting. ■

Doctor Rinek is chairman of the MSMS Committee on State Legislation and Regulations.

VIEWPOINT

Surviving the Insurance Crisis

Isn't Enough

By Thomas R. Berglund, MD

Some 15 years after the mid-1970s' malpractice insurance crisis and nearly three years since the 1986 "tort reforms," most physicians here have survived, but are still plagued by, liability problems.

From a perspective of having endured the crisis, let's be clear about some facts and consequences:

1. Insurance companies are not the culprits. Despite minimal commitment and perhaps no allegiance to the medical community, commercial insurers did not cause the crisis. Physician-owned companies certainly aren't to blame.

2. The tort system encourages litigation; and the definition and concept of liability have been expanded and distorted. The system has been abused, sometimes creatively, but at the expense of physicians and their insurers.

3. Realistic and practical limits must be placed on awards, settlements and legal costs.

4. Physicians are making concerted efforts at risk management and better patient relations; insurers are rewarding those efforts with premium reductions.

5. Tort reforms haven't reduced professional liability premiums in any state; reductions aren't feasible without substantive changes in the system.

6. Joint underwriting associations, patient compensation funds and no-fault programs haven't resolved or even alleviated the problems. They may have made matters worse.

Lawyers shift gears

The liability crisis of the mid-1970s was generally perceived as a lawyer-versus-doctor problem. Lawyers blamed doctors, saying incompetent physicians caused great harm to patients and that litigation, even if a bitter pill, was the cure.

We know that's an over-simplification of a complex issue. All of society has been swept into a lawsuit crisis. That crisis is fueled by a notion that someone or something is responsible and should pay for all misfortunes.

In some respects, we still play the "blame game." But lawyers and self-styled "consumer advocates" have a new strategy. More recently, they blame insurance companies.

They point to annual premiums and compare them to annual claims payouts, calling the difference "profit" and labeling it excessive and a "rip-off."

Unfortunately, some legislators, news reporters and others — including many physicians — believe them.

As president and chairman of the board for Michigan Physicians Mutual Liability Company (MPMLC), I say the facts destroy any notion of an insurance industry rip-off.

The "long tail" impact

There's a simple reason insurance premiums exceed claims payouts in a single year. It's because it takes 10 years or more to resolve and pay all the claims related to a calendar-year's incidents.

Even after five years, only 78 percent of all claims arising from a calendar year of incidents are paid — 22 percent are unpaid. After seven years, 10 percent of payout is still pending. Little wonder calendar-year premiums exceed calendar-year payouts.

This delayed payout is what industry insiders, analysts, and now many physicians, call the "long tail" effect.

The long tail traditionally has made medical liability insurance a volatile, unpredictable and frustrating line of business. Changes in law can extend the long tail or make this line of business more unpredictable.

It accounts for companies discontinuing medical liability coverage, going bankrupt or struggling to recover from devastating costs. MPMLC, approaching 13 years of providing liability protection to physicians, is fortunate to be able to renew its commitment to the medical community.

We, as a company, are survivors along with physicians who still practice here. Our financial stability and strength are improving. We share the medical community's interest in liability remedies and solutions.

What about no-fault?

Theoretically, our professional liability and tort system is based on fault: Wrongdoing that involves failure to adhere to standards, resulting in injury.

Case records support the view that the tort system has gone afield of this framework. Physicians are sued when there is no breach of standard and too many of those cases result in payouts.

Frustration with this trend has led to speculative and hopeful searches for alternatives — including no-fault programs.

Experts in the insurance actuarial and management consulting field, notably Tillinghast, say no-fault isn't the answer.

They say no-fault programs increase the number and ultimate cost of medical liability claims, and physicians and hospitals continue to carry the financial bag.

With no-fault's guaranteed payout, claims not associated with fault would be filed. Tillinghast actuaries suggest five to ten times more claims would be filed under a no-fault system.

In addition to generating more claims and payouts, a no-fault system would increase administrative costs. It would be essential to determine injury, the extent of it and whether it resulted from medical care.

In contrast, no-fault auto insurance has the certainty of a car accident and the system doesn't increase the number of auto crashes.

MPMLC, like most insurers associated with Physician Insurers Association of America (PIAA), still believes in vigorously defending policyholders when there is no malpractice.

Most physicians expect — even demand — repudiation of non-meritorious claims. But that's just one dimension of the problem. Recently, it's become essential to legally challenge excessive, over aggressive demands. Even if there is liability, overzealous demands should be contested.

The tort system, inherently adversarial, exacts a high cost for legal defense efforts. Vindication has a price — and insurers, understandably, must factor it into premiums.

New theories of liability

Not long ago, MPMLC was forced to settle what had been a defensible case involving a general practitioner.

Plaintiff argued that the GP should be held to standards of an OB because his yellow pages ad read "general practice and obstetrics." The court accepted that argument.

MPMLC had no supportive OB testimony. Plaintiff had an OB expert armed and ready to fire the courtroom salvo. The case was settled prior to trial — for $80,000.

This is one example of how the definition and bounds of liability have expanded, creating new legal arguments for new demands.

Caution and risk management

Until the system changes, a physician should proceed with caution and take advantage of good risk management programs, services and procedures. MPMLC is encouraging this by giving policyholders premium reductions for certain risk management activities.

Our company began risk management activities in 1979 — long before legislative leaders urged insurers to provide risk management incentives.

Risk management is one way we have to survive the crisis, but, without doubt, we should expect more than survival.

Physicians strive to improve the quality of life of their patients. It may be time for society and the legislature to address the public policy elements in the liability climate.

That climate threatens our practice, is causing many physicians to think twice about practicing here, and could impede the availability of certain medical care services. ■

Doctor Berglund is president and board chairman, MPMLC.

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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

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Reference:
1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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ARMY RESERVE MEDICAL PROFILE NO. 5

ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

EDUCATION Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience;* Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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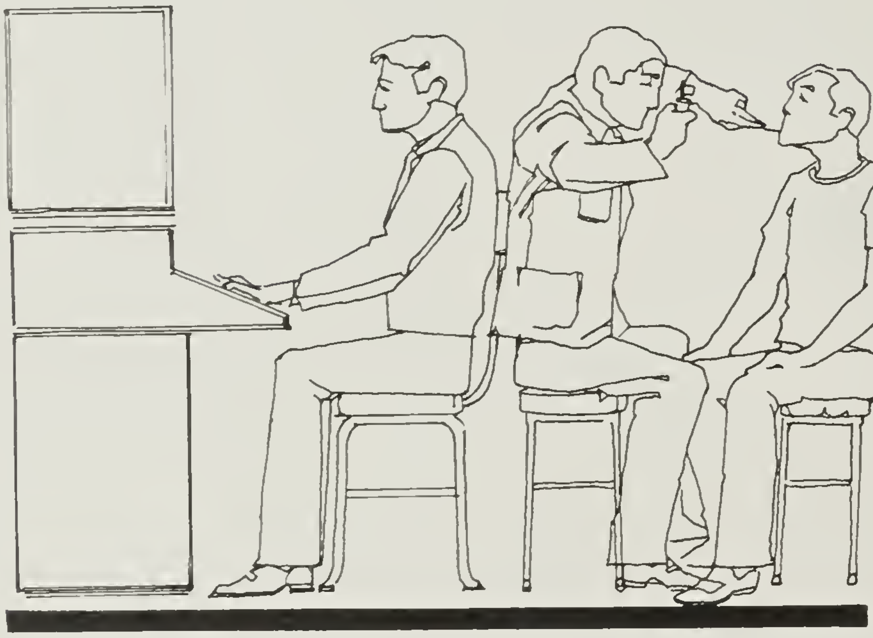
MMGMA

Providing Better Business for Doctors

By Chad B. Munger



As medicine becomes an ever more complex business, the need for better organization and greater expertise in financial, marketing and technical business skills becomes a requirement for success. Often, obtaining these skills is not a practical or desirable part of a physician's professional life.

Medical group practice is one important tool being used on a large scale to relieve the pressure of being both a businessperson and a physician. The medical group manager is a key figure in the success of these group practices.

"Managers must be experts in the details of running a business," says James E. Long, MMGMA past president. "We (managers) run the business and let the physicians concentrate on medicine."

"Losing control" can be difficult

For physicians who are trained to rely on their own knowledge, it is often difficult to give up control of part of their professional lives, as one physician attests.

"It is a difficult thing for a physician to give up managing his office," says Thomas R. Berglund, MD, who is a member of a large OB/GYN group in Kalamazoo. "When a physician finally does, however, he realizes how beneficial it is for him to have someone else manage the office."

In response to the growing number of medical groups and group managers in Michigan, the Michigan Medical Group Management Association (MMGMA) was formed in 1973.

MMGMA is an association of business professionals who are in charge of the non-medical aspects of medical practices across Michigan. Association members come from practices of three or more physicians. Members come from free-standing primary care, specialty and university-affiliated groups. Regardless of the size of their practice, physicians are turning to MMGMA for the same reason: to fulfill their need for specialized management in the health care setting.

History of MMGMA

MMGMA was created with two objectives in mind. The first objective: to offer assistance in dealing with problems unique to the medical profession in Michigan. Medical liability, concerns about labor organizations and clinics, reimbursement from Medicaid and Blue Cross Blue Shield were key concerns at the time MMGMA was founded, according to Long.

The second objective: to bring the advantages of contact with a peer group to individuals who could only interact on a local level.

MMGMA strives to provide peer interaction and the opportunity to exchange ideas and knowledge about management techniques and the technology associated with it, says Long.

"Through bi-annual conferences, MMGMA has developed a network of management professionals who share common problems and solutions in the management of a medical practice," Long explains. "By sharing ideas with the smaller group of managers who are active at the national level, all of MMGMA's members reap the benefits of that larger experience."

etworking important

Medical group management tends to be somewhat isolating profession. Group anagers often work alone or with very ttle staff, and often without the benefit of aily contact with their peers. This aspect f the profession is a challenge to both the ersonal and professional development of e manager. MMGMA is an excellent way keep managers in touch with one an- ther, says Edward Porter, MMGMA presi- ent.

"Everybody gets publications that try to eep the manager in touch," he says. "But ometimes, learning how to be an effec- ve group manager is more easily done ver a cup of coffee than by reading a ook."

The president is keenly aware of the val- e of providing the "how to" of manage- ent on a grass roots level.

Beyond networking

Another key element of MMGMA's lead- rship role in medical group management s hands-on, up-to-the-minute education.

MMGMA membership is an excellent way to keep group managers on top of the management world, says Doctor Berglund. "We know that our manager is increasing his knowledge and skills by being a part of MMGMA. Our manager often finds new systems and hardware that can be utilized in our practice."

Doctor Berglund's manager is but one of many who are turning to MMGMA for education. Evidence of this is the large number of association members who have — or are about to become — fellows of the American College of Medical Group Administrators (ACMGA).

Becoming an ACMGA fellow requires research and formal education, and reflects a strong commitment to the profession.

Providing a professional link to the medical community is yet another function of MMGMA. In recent years, MSMS has asked MMGMA members to serve as active MSMS committee members. This relationship allows managers to interact directly with political, social and medical issues effecting both physicians and managers.

"The political goals of MMGMA and MSMS are often quite similar," says Doctor Berglund, who serves on the MSMS Board of Directors. "MMGMA members provide yet another perspective from which to approach the business of providing quality health care."

Strong growth

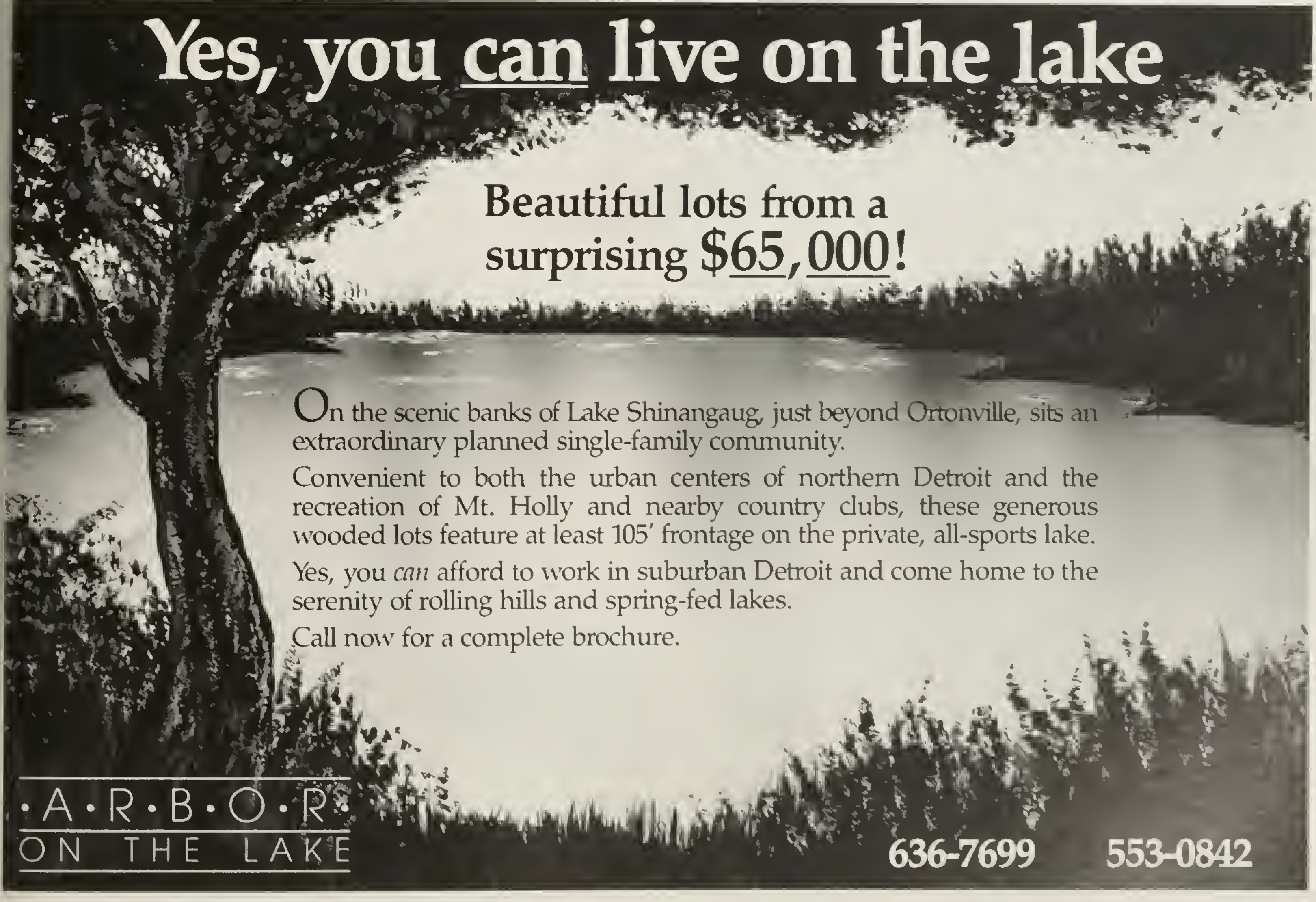
Starting with only 14 members in a small Fenton, Michigan, medical center, MMGMA is now over 200 members strong — and is still growing.

By contracting out their executive secretarial functions, MMGMA has been able to reach more clinics. As a result, their membership has almost doubled — from 106 in 1987 to 210 in 1988.

"For most medical groups, the value of developing and maintaining an effective group manager far outweighs the cost of membership and the inconvenience of providing a few days per year for education and networking opportunities," Porter concludes.

Managers interested in joining MMGMA are encouraged to contact Edward Porter, MMGMA president, at (616) 381-2920, or Caroline Kimmel, executive secretary, at (517) 337-1351.

The author is an East Lansing-based freelance writer.



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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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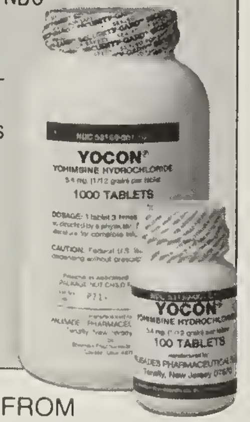

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The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Grover R. Fattic, Jr., MD
Action, Date Taken: Voluntary surrender, January 18, 1989.
Reason: Drug related

Name: Maimoona H. Husain, MD
Action, Date Taken: Suspended, one year; fined $5,000, January 20, 1989.
Reason: Drug related

Name: John C. Long, MD
Action, Date Taken: Reprimand; fined $1,000, February 17, 1989.
Reason: Incompetency

Name: Nathan E. Pearson, MD
Action, Date Taken: Revoked, January 9, 1989.
Reason: Drug related

Name: Juan G. Posada, MD
Action, Date Taken: Reprimand, probation 1 year, fined $1,500.
Reason: Negligence-incompetency

Name: John Anthony Taylor, MD
Action, Date Taken: Summarily Suspended, January 18, 1989
Reason: Physically-mentally impaired

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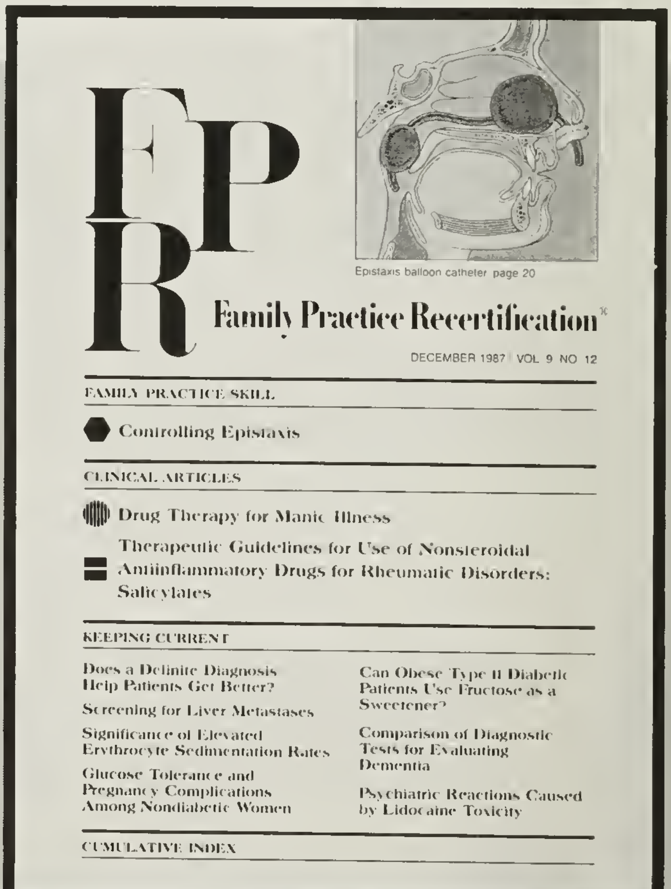

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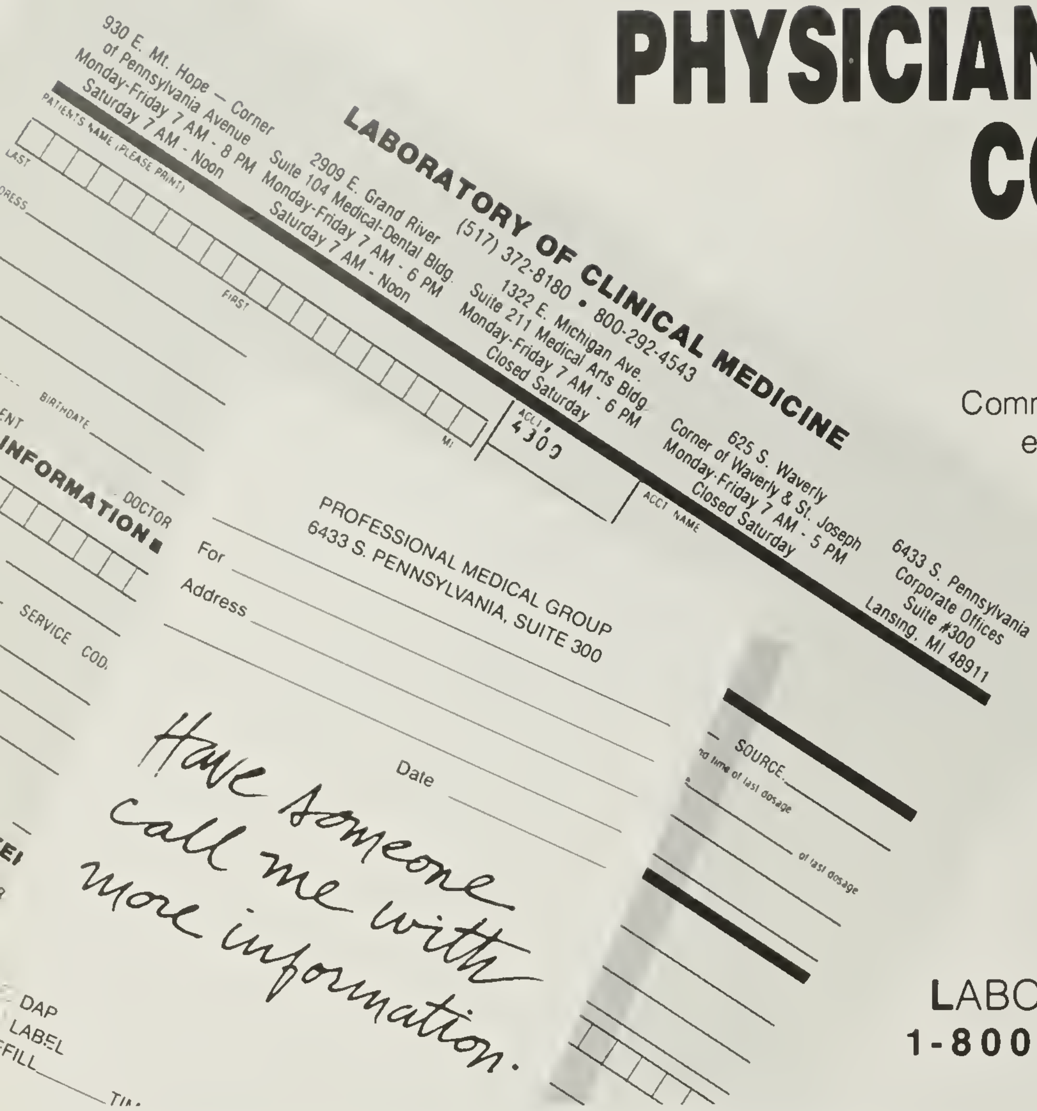

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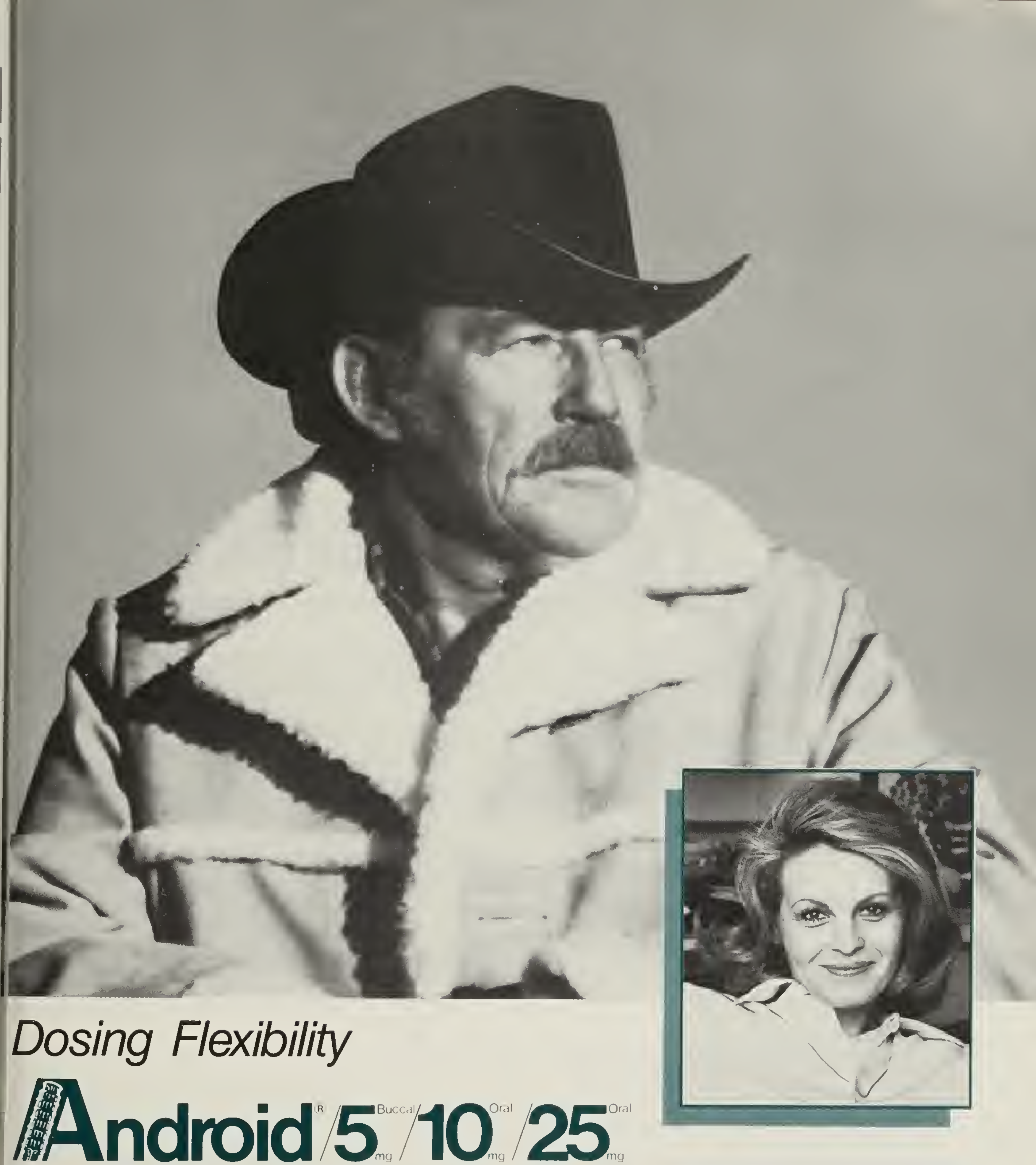

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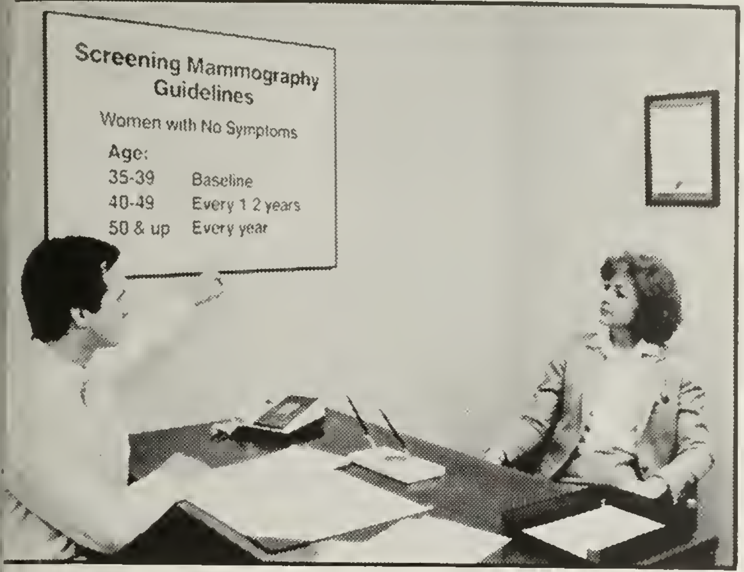

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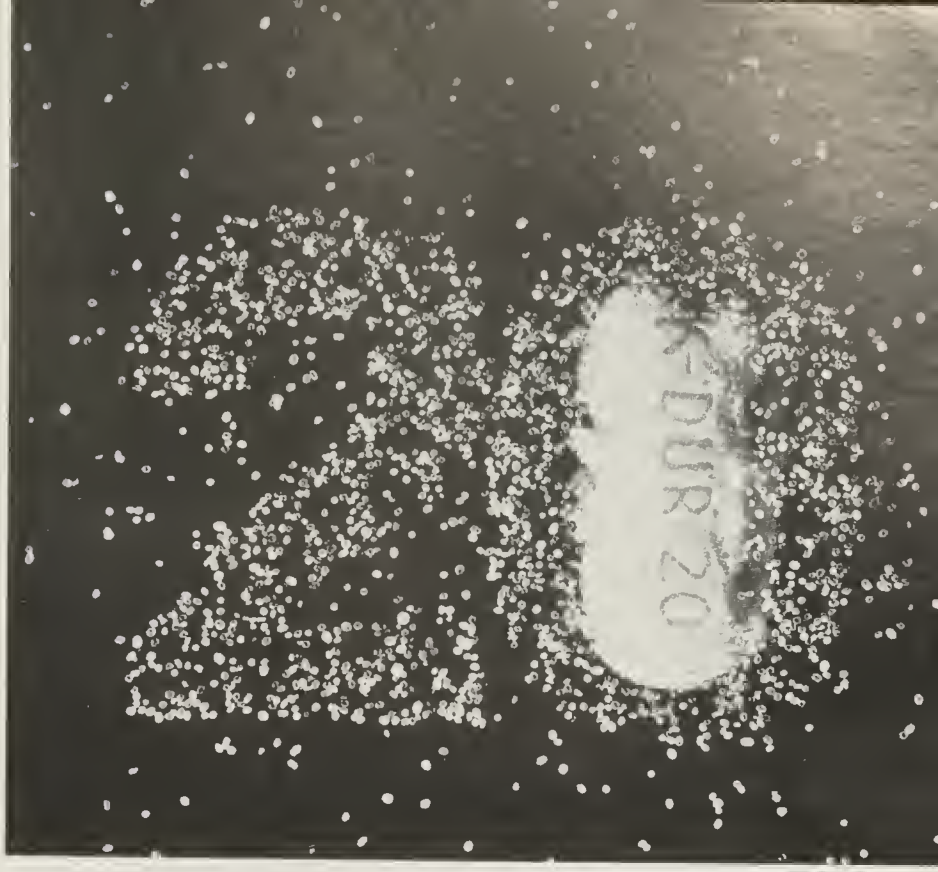

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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1 For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2 For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3 The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation

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Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics, see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval) Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.

2 Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.

3 Correction of acidosis, if present, with intravenous sodium bicarbonate

4 Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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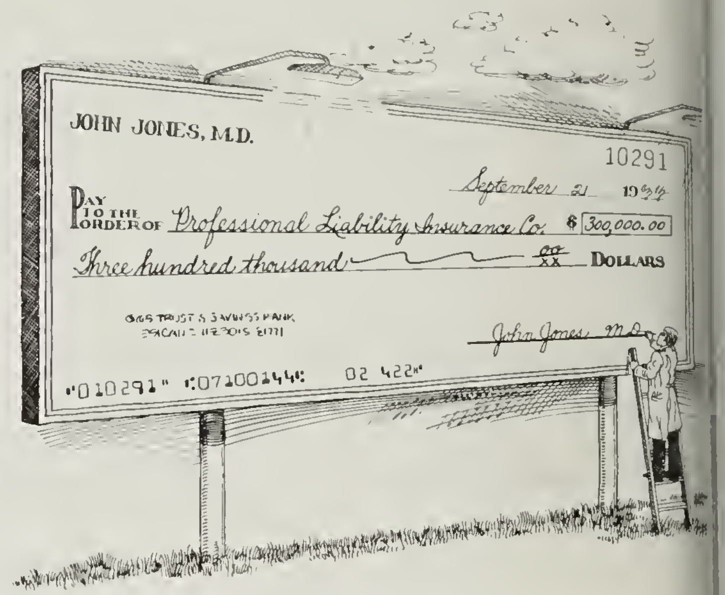
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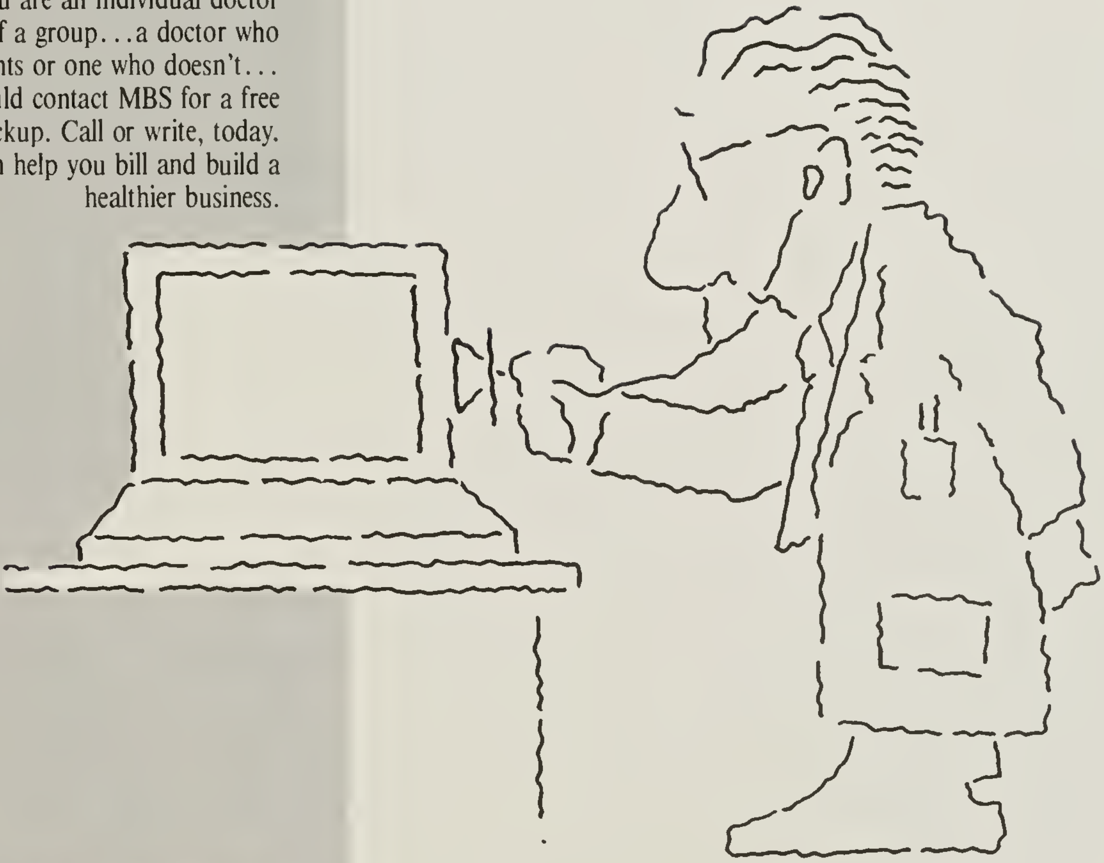

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DEATHS

Robert H. Berman, MD
Bloomfield Hills

Doctor Berman, a retired Bloomfield Hills cardiologist, died December 2, 1988, at the age of 90. Born in Brazil, Doctor Berman lived in Detroit for more than 88 years. He received his medical degree from the University of Michigan Medical School in 1926 and practiced in Detroit until his retirement in 1983. He was a fellow of the American College of Cardiology, a fellow of the American College of Chest Physicians, and a member of the Wayne County Medical Society.

James Rieden, MD
Birmingham

Doctor Rieden, a Birmingham general surgeon, died December 16, 1988, at the age of 77. He practiced for 45 years at Providence Hospital before retiring in 1980. A graduate of the University of Detroit and Wayne State University School of Medicine, he was a member of the American College of Surgeons, Detroit Surgical Society, Detroit Academy of Surgeons, Wayne County Medical Society and the American Medical Association.

James G. Malone, MD
Kalamazoo

Doctor Malone, former chief of staff at Bronson Methodist Hospital, died December 31, 1988, at the age of 83. He practiced internal medicine at Bronson from 1931 until his retirement in 1972. He served in the US Army Air Corps in World War II, where he attained the rank of major. A 1929 graduate of the University of Michigan Medical School, he spent two years as an intern at Harper Hospital in Detroit. He was president of the Kalamazoo Academy of Medicine in 1959. In 1979 the medical society honored him for 50 years as a physician.

Abraham J. Botting, MD
Grand Rapids

Doctor Botting, a retired Grand Rapids family practitioner, died December 5, 1988, at the age of 77. Doctor Botting received his medical degree from the University of Michigan in 1936. He was in general practice in Ionia County and transferred to Kent County in 1946. He was in practice in Byron Center until illness forced his retirement from practice in 1974. Doctor Botting was a member of the Kent County Medical Society.

Polibio A. Dilone, MD
East Detroit

Doctor Dilone, a staff physician at Detroit's Saratoga General Hospital for 20 years, died December 7, 1988, at the age of 64. He also held a private family practice in East Detroit. He was a 1954 graduate of the University of Santo Domingo Medical College in the Dominican Republic. He served his medical internship at Coney Island Hospital in New York, and his residency in pathology at Hanneman Medical College of Philadelphia, Pa. He was a member of the Macomb County Medical Society and the American Medical Association.

Cyril R. Defever, MD
Grosse Pointe Park

Doctor DeFever, a Grosse Pointe Park general surgeon, died December 21, 1988, at the age of 82. He was a graduate of the University of Detroit and the Wayne State University School of Medicine. He served in the US Navy as a lieutenant commander during World War II. Doctor DeFever was a member of the International College of Surgeons, the American College of Surgeons, the Wayne County Medical Society, and the American Medical Association.

Winthrop D. Hall, MD
Dearborn

Doctor Hall, a retired Dearborn internist, died December 28, 1988, at the age of 76. He was a 1937 graduate of the University of Michigan, where he received his degree in pharmacy with honors. He also received a degree from the Wayne State University School of Medicine in 1947. He served on the staff of Oakwood Hospital for more than 30 years. He retired from private practice in 1982 and later served on the emeritus staff at Oakwood Hospital. Doctor Hall was a member of the American Academy of Family Practitioners and the Wayne County Medical Society.

Donald I. Kapetanksy, MD
Southfield

Doctor Kapetansky, a plastic surgeon at Providence Hospital, died December 22, 1988, after the twin-engine aircraft he was flying crashed near Toledo, Ohio. He was 58. An author and teacher in the field of plastic and reconstructive surgery, Doctor Kapetansky was reknowned for aiding children with palate disorders. He was the director of the Detroit Cleft Palate and Maxillofacial Deformities Clinic at Sinai Hospital, Detroit. He also was affiliated with Providence, Childrens' and Henry Ford hospitals. He received a US Army Commendation Medal for meritorious achievement with burn patients in 1960. After the 1973 Yom Kippur War in Israel, he flew to Israel to treat burned Israeli Civilians and soldiers. A 1954 graduate of the University of Michigan Medical School, he recently was awarded a teaching fellowship at the medical school.

Fred G. Swartz Jr., MD
Suttons Bay

Doctor Swartz, a former Grosse Pointe resident, died December 5, 1988, at the age of 70. He held a private psychiatric practice in Detroit and Grosse Pointe from 1949 until 1982, when he retired and moved to the Grand Traverse area. Doctor Swartz received his medical degree from the University of Michigan Medical School in 1941. He was a member of the Michigan Society of Neurology and Psychiatry and the American Psychiatric Association, and served as a consultant to the Detroit Board of Education. He was a battalion surgeon with the 104th Infantry Division during World War II and was awarded Bronze and Silver Stars for bravery in action.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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5912 Glen Eagles Drive
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Eric N. Backos, MD — PM
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MSMS Meetings

March

17-18, MSMS Section for Graduates of Foreign Medical Schools, Ritz Carlton, Dearborn, Contact: Judith E. Marr, MSMS Section for Graduates of Foreign Medical Schools, (517) 337-1351.

22-23, Michigan Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyond The Horizon" Hyatt Regency Dearborn, Contact: Sherry L. Fent, MSMS Chief of Physician Education, (517) 337-1351.

May

5-7, MSMS Board of Directors and House of Delegates, Hyatt Regency Dearborn, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

8-10, MSMS Auxiliary Annual Session, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, MSMS/Physician Service Group, Account Executive, (517) 337-1351.

11, MSMS Conference on Sports Medicine, Hilton Inn, Lansing, Contact: Sherry L. Fent, MSMS Chief of Physician Education, (517) 337-1351.

AMA Meetings

May

10-12, AMA First International Congress on Peer Review in Biomedical Publication, Congress Hotel, Chicago, Illinois, Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-4417.

June

18-22, AMA House of Delegates Annual Meeting, Chicago Hilton, Chicago, Illinois, Contact: AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-5000.

Michigan Specialty Society Meetings

March

24-25, Michigan Psychoanalytic Society, The Psychoanalytic Process: Theory, Clinical Observation, & Empirical Research, Southfield, Michigan, Contact: Shirley Seffinger or Colleen Jaeger, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076 (313) 557-8633 or (313) 559-5855.

April

18-21, Michigan Society for Respiratory Care, 31st Annual Respiratory Care Symposium, Amway Grand Plaza Hotel, Grand Rapids, Michigan, Contact: Michigan Society Respiratory Care, P. O. Box 950, East Lansing, MI 48826 or Caroline Kimmel at (517) 337-1351.

20, Michigan Ophthalmological Society Monthly Scientific Meeting, Novi Hilton, Novi, Contact: Christine A. Jourdain, 412 Eastland Professional Building, Harper Woods, MI 48225 (313) 839-3011.

27-30, Michigan Society of Medical Assistants, Annual Convention, Sheraton Inn, Lansing, Contact: Cathy Gunder, CMA, 7799 S. Clinton Trail, Eaton Rapids, MI 48827.

28, Michigan Thoracic Society/American College of Chest Physicians, Michigan Chapter, Annual Scientific Sessions, Sheraton Oaks Hotel and Conference Center, Contact: Robert E. Klimek, MD, 337 Chesterfield Parkway, East Lansing, MI 48823 (517) 334-2345.

May

4-5, Michigan Chapter, American College of Surgeons, "Coller Day Competition and Scientific Session" Sheraton University Inn, Ann Arbor, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

11, Michigan Psychoanalytic Society, "The Invisible Loss: Dynamics and Treatment of Perinatal Sibling Death," Southfield, Michigan, Contact: Shirley Seffinger or Colleen Jaeger, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076 (313) 557-8633 or (313) 559-5855.

June

1-2, Michigan Occupational Medical Association Spring Scientific Seminar, Bay Valley Hotel and Resort, Bay City, Contact: John Bernick, MD, 20900 West Road, Woodhaven, MI 48183 (313) 671-7251.

3, Michigan Society of Pathologists Spring Meeting, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

22-24, Michigan Orthopaedic Society Annual Meeting, Boyne Highlands, Contact: Arthur Manoli, II, MD, Orthopaedic Surgery, Hutzel Hospital, 4707 St. Antoine, Detroit, MI 48201 (313) 745-6955.

22-25, Michigan Otolaryngologic Society, Annual Statewide Meeting, Contact: Karen Turner, Wayne County Medical Society, 1010 Antietam Road, Detroit, MI 48207 (313) 567-1640.

July

10-12, Sixteenth Michigan Emergency Medicine Assembly/Annual Meeting, Grand Hotel, Mackinac Island, Contact: Kathryn Hopkins, 500 Lansing Road, Charlotte, MI 48813 (517) 645-8050.

31-8/2, Michigan Academy of Family Physicians, 43rd Annual Scientific Assembly Grand Traverse Resort, Acme, Contact: Julie Nelson, 109 East Oakland, Lansing, MI 48906 (517) 482-7410.

National Specialty Society Meetings

March

19-23, American College of Cardiology, Annual Scientific Meeting, Hilton Inn, Anaheim, CA, Contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 (301) 897-5400.

19-24, American Association of Pathologists, Annual Meeting, New Orleans, LA, Contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814 (301) 530-7130.

31-4/4 American Orthopsychiatric Association, 66th Annual Meeting, New York Hilton, New York, NY, Contact: American Orthopsychiatric Association, 19W 44th Street, New York, NY 10036 (212) 354-5770.

April

2-6, American Association of Neurological Surgeons, Annual Meeting, Washington, DC, Contact: American Association of Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312) 692-9500.

2-6, American College of Surgeons, Spring Meeting, Marriott & Westin Hotels, Copley Plaza, Boston, MA, Contact: American College of Surgeons, 55 East Erie Street, Chicago, IL 60611 (312) 664-4050.

4-6, American Laryngological, Rhinological and Otological Society, Annual Scientific Meeting, Fairmont Hotel, San Francisco, CA, Contact: The Triological Society, P. O. Box 155, East Greenview, PA 18041 (215) 679-7180.

6-8, American College of Obstetrics and Gynecologists, Antepartum Fetal Assessment, Grand Hyatt, New York, NY, Contact: American College of Obstetrics and Gynecologists, 600 Maryland Avenue SW, Suite 300, Washington, DC 20024 (202) 863-2543.

10-12, American Surgical Association, Colorado Springs, CO, Contact: H.C. Polk, Jr., MD, Department of Surgery, University of Louisville, Louisville, KY 40292 (502) 588-5585.

12-16, American College of Preventive Medicine, Annual Scientific Meeting, Westin Hotel, Atlanta, GA, Contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202) 789-0003.

MEETINGS

13-16, American College of Physicians, Annual Meeting, San Francisco, CA, Contact: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104 (215) 243-1200.

13-19, American Academy of Neurology Annual Scientific Meeting, Hynes Convention Center, Chicago, IL, Contact: American Academy of Neurology, 2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612) 623-8115.

14-26, American Academy of Pediatrics, Pediatrics in Progress, Tropicana Hotel, Las Vegas, NV, Contact: American Academy of Pediatrics, 141 Northwest Point Blvd. Elk Grove Village, IL 60009 (800) 433-9016.

16-19, College of Osteopathic Healthcare Execs; American Osteopathic Hospital Association, Annual Meeting, Scottsdale, Arizona, Contact: (703) 684-7700.

22-25, Society of Cardiovascular Anesthesiologists, 11th Annual Meeting, Washington State Convention Center, Sheraton, Seattle, Washington, Contact: Society of Cardiovascular Anesthesiologists, P. O. Box 11086, Richmond, VA 23230 (804) 257-7154.

28-5/1, Association of American Physicians; American Society for Clinical Investigation, 1989 Annual Meeting, Sheraton, Washington, DC, Contact: Association of American Physicians, 660 S. Euclid Avenue, Box 8125, St. Louis, MO 63123 (609) 848-1000.

29-5/5, American Occupational Medical Association, Annual Scientific Meeting, Sheraton Boston, Boston, MA, Contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312) 228-6850.

30-5/3 American College of Physician Executives, National Conference on Health Care and Management, The Grand Hyatt, Washington, DC, Contact: (813) 287-2000.

May

3-7, American Psychoanalytic Association, 78th Annual Meeting, Hyatt Regency at Embarcadero Center, San Francisco, CA, Contact: American Psycoanalytic Association, 309 E. 49th Street, New York, NY 10017 (212) 752-0450.

6-12, American Psychiatric Association, Scientific Meeting, San Francisco, CA, Contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005 (202) 682-6000.

7-10, American Association of Plastic Surgeons Annual Meeting, Camelback Inn, Scottsdale, AZ, Contact: American Association of Plastic Surgeons, The Johns Hopkins Hospital, 601 N. Wolfe Street, Harvey 811, Baltimore, MD 21205 (301) 669-7601.

7-11, American Urological Association Annual Meeting, Infomart/Loews Anatole Hotel, Dallas, TX, Contact: American Urological Association, 1120 N. Charles Street, Baltimore, MD 21201 (301) 727-1100.

8-10, American Association for Thoracic Surgery, Annual Meeting, Sheraton/Hynes, Boston, MA, Contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

11, American College of Emergency Physicians, Occupational Medicine, Holiday Inn Crowne Plaza, Atlanta, GA, Contact: American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911 (214) 550-0911.

11-14, American Geriatrics Society; American Federation for Aging Research, 46th Annual Meeting, Marriott Copley Place, Boston, MA, Contact: American Geriatrics Society, 770 Lexington Avenue, Suite 400, New York, NY 10021 (212) 308-1414.

13-17, American Society for Gastrointestinal Endoscopy Annual Scientific Meeting, Sheraton Hotel, Washington, DC, Contact: American Society for Gastrointestinal Endoscopy, Thirteen Elm Street, Manchester, MA 01944 (617) 927-8330.

13-19, American Gastroenterological Association Annual Scientific Meeting, Sheraton Washington and Shoreham Hotels, Washington, DC, Contact: American Gastroenterological Association, 6900 Grove Road, Thorofare, NJ 08086 (609) 848-1000.

14-17, American Thoracic Society Annual Scientific Meeting, Convention Center, Cincinnati, OH, Contact: American Thoracic Society, 1740 Broadway, New York, NY 10019 (212) 315-8778.

21-23, American Society of Clinical Oncology, Annual Meeting and Exhibit Show, Moscone Center, San Francisco, CA, Contact: American Society of Clinical Oncology, 435 N. Michigan Avenue, Suite 1717, Chicago, IL 60611 (312) 644-0828.

22-25, American College of Obstetricians and Gynecologists, Annual Meeting, Convention Center, Atlanta, GA, Contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024 (202) 638-5577.

28-31, American Pediatric Surgical Association, Annual Meeting, Hyatt Regency Inner Harbor, Baltimore, MD, Contact: American Pediatric Surgical Association, Johns Hopkins Hospital, Baltimore, MD 20105 (301) 955-6256.

31-6/3, American College of Sports Medicine, Baltimore, MD, Contact: American College of Sports Medicine, P. O. Box 1440, Indianapolis, IN 46206-1440 (317) 637-9200.

June

11-15, American Society of Colon and Rectal Surgeons, Annual Meeting, Sheraton Centre, Toronto, Ontario, Canada, Contact: American Society of Colon and Rectal Surgeons, 615 Griswold, Suite 1717, Detroit, MI 48226 (313) 961-7880.

12-15, American Orthopedic Association, Annual Scientific Meeting, The Broadmoor, Colorado Springs, CO, Contact: American Orthopaedic Association, 222 S. Prospect Avenue, Park Ridge, IL 60068 (312) 823-7186.

13-16, The Society of Nuclear Medicine, Annual Scientific Meeting, St. Louis, MO, Contact: The Society of Nuclear Medicine, 136 Madison Avenue, New York, NY 10016 (212) 889-0717.

September

10-13, Society of Thoracic Surgeons, Annual Meeting, Convention Center, Baltimore, MD, Contact: Society of Thoracic Surgeons, 111 E. Wacker Drive, Suite 600, Chicago, IL 60601 (312) 644-6610.

10-14, American College of Radiology, Annual Meeting, Westin Hotel, Seattle, WA, Contact: American College of Radiology, 1891 Preston White Drive, Reston, VA 22091 (703) 648-8900.

Other Meetings

April

17-18, Thirteenth Annual Conference of the Michigan Association for Infant Mental Health: Expanding Our Approaches with Families — Attachment, Intervention, and Social Policy, Ann Arbor, Contact: Ann Saffer, 2340 Hickman Road, Ann Arbor, MI 48105 (313) 994-8168.

27, Workplace Wellness, Ann Arbor, Contact: The University of Michigan Fitness Research Center, 401 Wastenaw Avenue, Ann Arbor, MI 48109, Pat Materka (313) 936-2895 or Marilyn Edington (313) 763-2462.

May

23, Marquette-Alger County Medical Society, Quarterly Meeting, Holiday Inn, Marquette, Michigan, Contact: Robert Manning, Executive Director, Marquette-Alger County Medical Society, P. O. Box 68, Marquette, MI 49855-0068 (906) 227-2913.

CATEGORY I COURSES

March

22-23, 28th Annual Conference on Maternal and Perinatal Health: "Perinatal Periscope: Looking Beyong the Horizon." Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P. O. Box 950, East Lansing, MI 48826-0950, (517) 337-1351. **Approved for:** 12 hours Category I Credit and 12.5 hours AAFP Prescribed Credit.

25-4/1, Facial Cutaneous Surgery: Mohs, Reconstructive, Cosmetic. Location: Copper Mountain Resort, Copper Mountain, Colorado. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology, Head and Neck Surgery. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 30 hours Category I Credit.

30-31, AIDS Education Program for Health Professionals. Location: McGregor Conference Center, Wayne State University. **Sponsors:** Wayne State University, College of Nursing in association with Department of Psychology. **Contact:** Ali Naqvi, MD or Jan Tomakowsky, MPH, Wayne State University, 5454 Cass, Room 210,Nursing Annex, Detroit, MI 48202 (313) 577-5549 or (313) 577-5731. **Approved for:** 13 hours Category I Credit.

April

2, Cardiovascular Update & Early Cancer Detection. Location: Conference Center, Mt. Pleasant Inn, Mt. Pleasant. **Sponsor:** CME Program of Central Michigan Community Hospital. **Contact:** Mary Jane Post, CME Coordinator, Central Michigan Community Hospital, 1221 South Drive, Mt. Pleasant, MI 48858-3234 (517) 772-6700. **Approved for:** 7 hours Category I Credit.

3-5, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 22 hours Category I Credit.

6-8, Eighteenth Annual Critical Care Symposium. Location: Kresge Auditorium, Harper Hospital. **Sponsors:** Detroit Receiving Hospital and Wayne State University School of Medicine. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201 (313) 745-3484. **Approved for:** 16.5 hours Category I Credit.

13-14, Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 15 hours Category I Credit.

16-19, Eighth Spring Conference — Extra Corporeal Membrane Oxygenation. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 30 hours Category I Credit.

17-19, Contemporary Concepts in Total Joint Replacement. Location: The Sonesta Beach Hotel & Spa, Bermuda. **Sponsor:** University of Michigan Medical School, Department of Surgery. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

22, Oncology Symposium. Location: Bay Valley Hotel & Resort, Bay City, Michigan. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City, MI 48708. **Approved for:** 5.5 hours Category I Credit.

26, Current Women's Health Care Issues. Location: Genevieve U. and Donald S. Gilmore, Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road, Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. **Approved for:** 6 hours Category I Credit.

26-28, Advances in Computer Tomography and Magnetic Resonance Imaging. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 22 hours Category I Credit.

May

11, MSMS Conference on Sports Medicine. Location: Hilton Inn, Lansing, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, Chief of Physician Education, Michigan State Medical Society, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351. **Approved for:** 6 hours Category I Credit.

11-12, The Restenosis Summit, An International Symposium with Live Demonstrations. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14.5 hours Category I Credit.

12, 11th Annual ACP-Michigan Chapter Associates Meeting. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** American College of Physicians, Michigan Chapter. **Contact:** Jan Rival, MD, FACP, Henry Ford Hospital, Department of Internal Medicine, 2799 Grand Boulevard, Detroit, MI 48202 (313) 876-1895 or 876-2059. **Approved for:** 6 hours Category I Credit.

14, Identification and Diagnosis of Mental Illness in the Developmentally Disabled. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road-Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. **Approved for:** 5.5 hours Category I Credit.

CATEGORY I COURSES

15-19, 17th Annual Spring Update: Advance in Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 34 hours Category I Credit.

19-20, Recent Advances in Cornea, External Disease, and Cataract: 61st Annual Ophthalmology Spring Conference. Location: W.K. Kellogg Eye Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

31-6/2, Current Topics in Blood Banking: 16th Annual Symposium and Workshops. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

June

1-2, Fifteenth Annual Sumposium for Michigan Neonatologists and Neonatal Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Neonatology Service, Bronson Methodist Hospital, (616) 341-6469. **Approved for:** 7.25 hours Category I Credit.

7-10, The 7th Annual Clinical Laboratory Computer Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 15 hours Category I Credit.

18-23, 25th Annual Northern Michigan Summer Conference. Location: Shanty Creek – Schuss Mountain, Bellaire, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

July

20-21, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Munson Medical Center, Traverse City. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386 (616) 922-9546. **Approved for:** 9-13 hours Category I Credit.

23-26, 3rd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

August

25-28, 15th Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 8109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

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PRESIDENT'S PAGE

Unity will be the cornerstone of my presidency

By Robert E. Paxton, MD

"Let us take time for a little introspection and, where necessary, modify our inherent, individualistic, dogmatic nature to preserve unity and perhaps even to secure survival."

My good friend, Fred W. Bryant, MD, relinquished his President's Page this month so that I could pen some of the goals I will establish as your president after I am installed May 6 at the MSMS House of Delegates.

When it comes to the written page, I'm no Fred Bryant. You will not have the opportunity to enjoy the gifted prose and distinctive vocabulary that Fred uses on this page. A writer I am not. What I will do is address very simply and pointedly the challenges facing both the medical profession and our patients as we approach the final decade of this century.

My purpose on this and future pages will be to stimulate interest, promote dialogue and encourage involvement, even if the subjects and the material might be provocative.

My basic philosophy is that a healthy society is one that is run by its members in a democratic fashion rather than controlled by a select few. That is why my intent is to arouse response from the membership.

Your future comments and input, whether supportive or critical, will be most welcomed and indeed germaine to any success we might obtain as we develop policy in this radically changing medical care arena.

While working in this arena, we face all of the problems generated by a cost containment- and budget-driven government and industry as well as a litigious, unconcerned public which does not understand the impact of national medical care nor the loss to it of a strained doctor/patient relationship. I am convinced that as we deal with these challenges, the importance of maintaining unity in our profession becomes paramount.

Unity is needed to achieve our goals

Striving for unity will become the cornerstone of my presidency because I feel that the need for unity permeates any and all of the activities we pursue. In fact, unity becomes mandatory in many of our crucial problems such as professional liability, physician reimbursement, threats from ancillary health care providers, and managed care.

The big question is how to achieve unity. I have no profound answer, but suggest some simple, down-to-earth commonsense solutions.

First, we need the will to unite! This should not be difficult, because the magnitude of our problems certainly motivates us to join together. Furthermore, the strength of those who oppose our ideals is formidable. We must act and speak as one dedicated, united profession.

Let us take time for a little introspection and, where necessary, modify our inherent individualistic, dogmatic nature to preserve unity and perhaps even to secure survival.

We must enter into productive dialogue with each other to appreciate the circumstances and needs of our colleagues in different specialties.

We must learn to compromise and put forth common goals.

We must maintain integrity and not allow financial gain to cloud our working relationships with each other.

Let MSMS be the umbrella organization within Michigan to facilitate this endeavor between the specialties. Let us resolve all of our internal differences without a contentious, antagonistic attitude. I want to share my hope and my optimism with you because it not only can be done, it must be done! ■

Doctor Paxton is MSMS president-elect.

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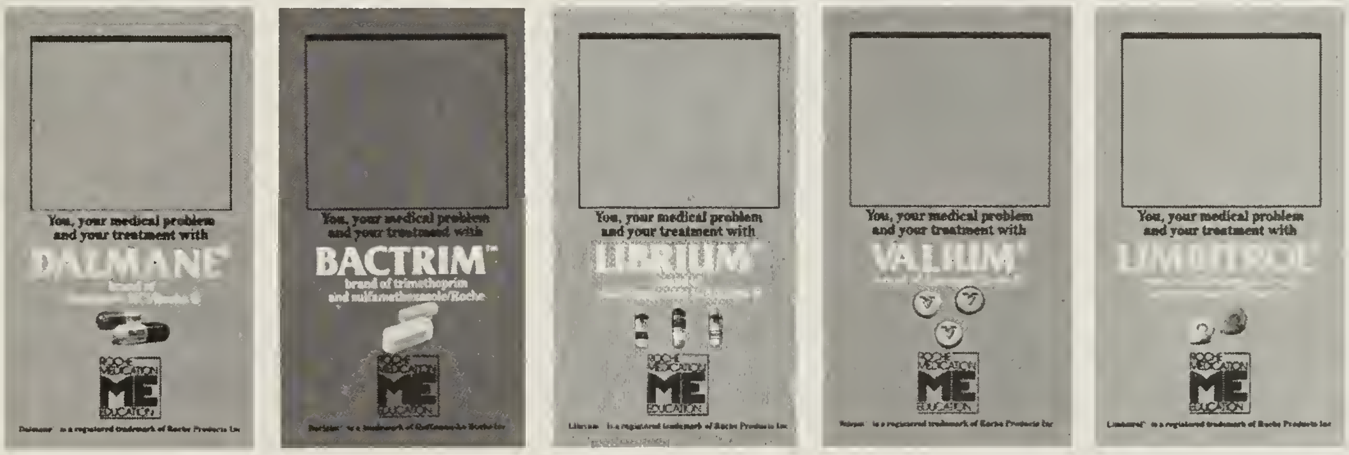
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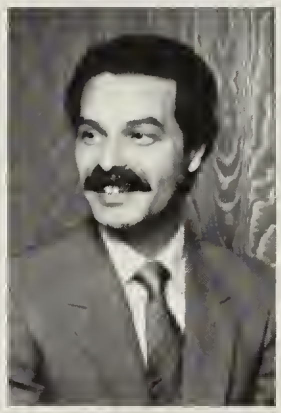
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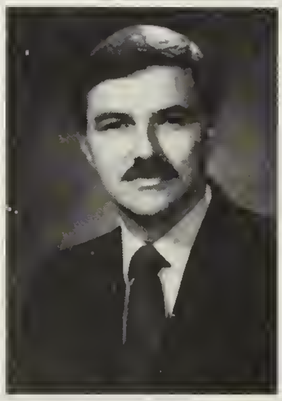
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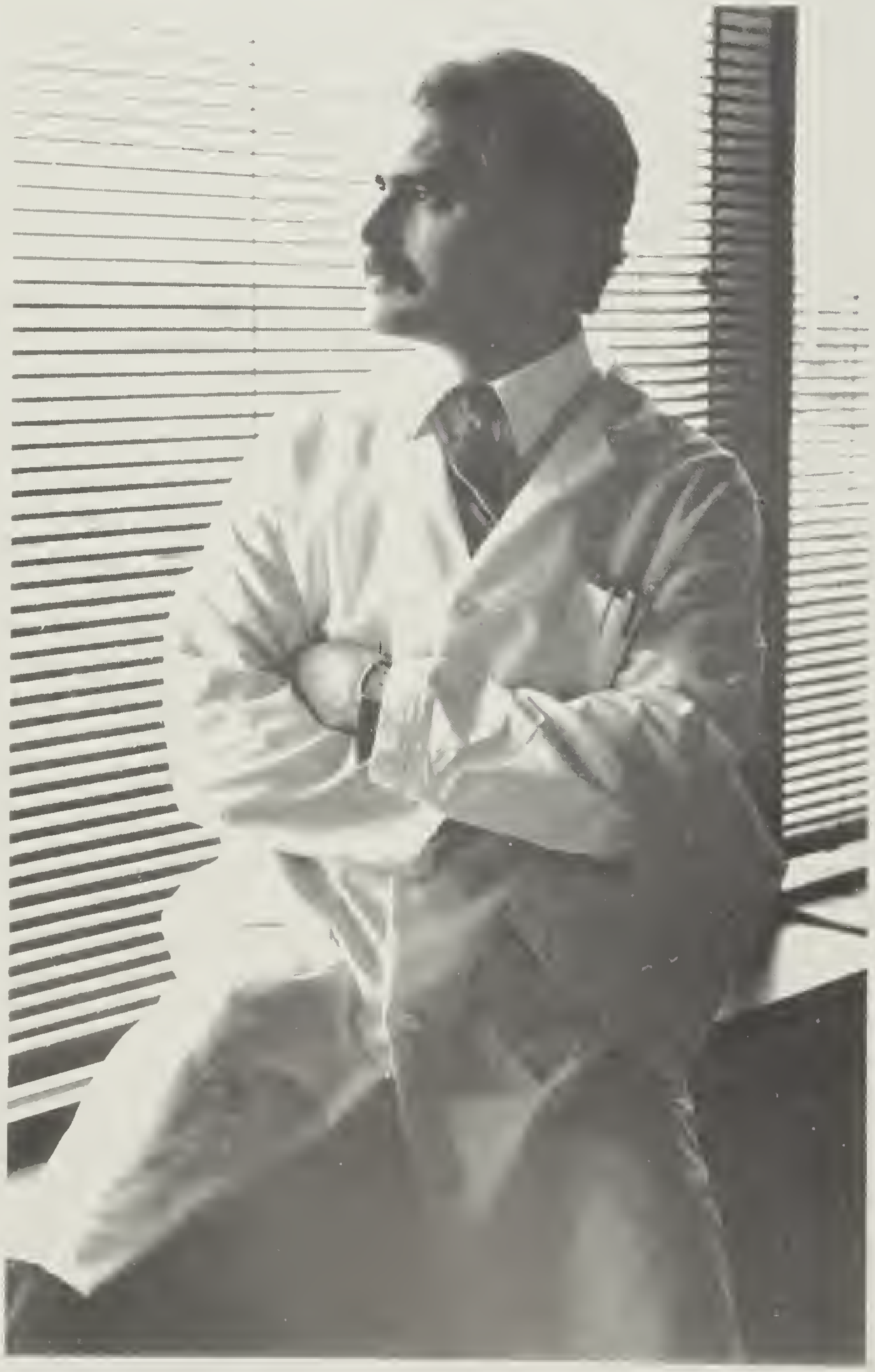

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Award-Winning Journal of the Michigan State Medical Society

APRIL 1989
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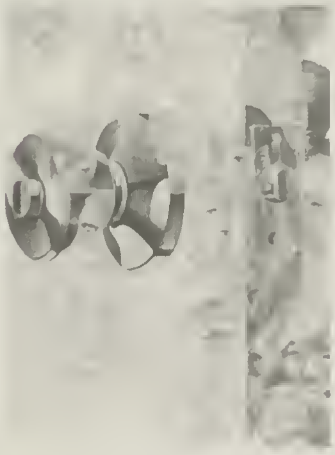

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Cover Story

Access to health care — the statistics are staggering, the consequences are devastating and the solutions are not easily found. Over 37 million Americans lack coverage for health care. In Michigan, one million residents are without any form of health insurance and, as in the rest of the country, the overwhelming majority of those uninsured are children and young adults. What can be done — and what is being done — to help open the door to health care for the uninsured is the subject of this month's cover story. Included in the cover story are: information on the Health Policy Agenda for the American People's recommendations on health care for the poor; an article about Michigan's Health Care Access Project; a review of program options under study by the Governor's Task Force on Access to Health Care; and a feature about some Michigan physicians who are voluntarily providing health care for the uninsured.

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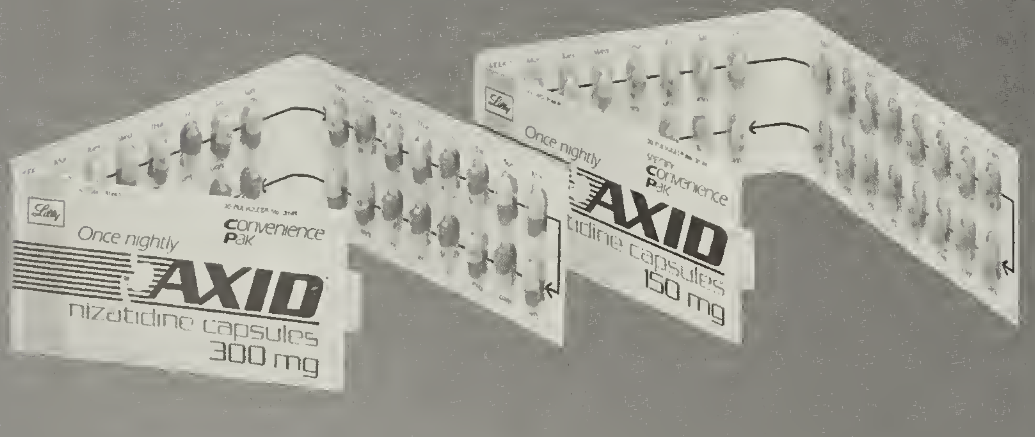

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists

Precautions: *General* – 1 Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy

2 Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency

3 Pharmacokinetic studies in patients with hepatorenal syndrome have not been done Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine

Drug Interactions – No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b i.d , was administered concurrently

Carcinogenesis, Mutagenesis, Impairment of Fertility – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers – Studies conducted in lactating women have shown that <0 1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations Caution should be exercised when administering nizatidine to a nursing mother

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Ulcer healing rates in elderly patients are similar to those in younger age groups The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0 2%), urticaria (0 5% vs < 0 01%), and somnolence (2 4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine

Hepatic – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects

CNS – Rare cases of reversible mental confusion have been reported

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred

Hematologic – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs Rare cases of thrombocytopenic purpura have been reported

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients Rash and exfoliative dermatitis were also reported

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered

Signs and Symptoms – There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively

Treatment – To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.

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[1] Data on file, Lilly Research Laboratories.

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IN MY OPINION

Health Care To The Uninsured A National Embarrassment

By Henry M. Domzalski, MD

The members of the MSMS Committee on Publications invite ***Michigan Medicine*** *readers to submit editorials for publication on this page.*

At any meeting attended by health, medical and governmental leaders and social planners, health care for the indigent ranks high on the agenda. And rightly so. The figures are dismal: 37 million Americans are without health care coverage; 23 percent of those working part-time are without coverage; 12.8 percent of those working full-time are without coverage.

Medicaid, General Assistance and other safety nets simply have not done the job. Many of these millions of Americans receive care sporadically, if at all. When a crisis involving their health descends upon them, what happens? They present themselves at the emergency departments of our hospitals or are found in the delivery rooms of our hospitals being attended by a physician who has never seen them before the eminent "happy event."

Each and every one of us — as physicians and taxpayers — and each and every hospital in this country is being affected. This "last minute" emergency care usually necessitates more intense and more prolonged hospitalization. Physicians are reluctant and wary of assuming responsibility because of perceived liability exposure. More importantly, physicians are frustrated at seeing fellow human beings in dire straights who may never have needed such intensity of care had they had prior access to decent care.

This rich land of ours simply cannot further tolerate this embarrassment. The private sector is doing a lot, but surely it cannot do it all. Government has failed as of this date. However, only Government has the means and the power to effect the needed changes.

The poor, the homeless, the very elderly, the non-white, and the disabled collectively do not represent a constituency with much clout in the legislative halls of this land. Others must speak out for them — all of them.

Physicians are eminently suited for this task. We are aware of the problem. Historically, physicians have been patient advocates and have cared for all patients equally without consideration of class or status. Therefore, it seems to me that we should be the "Pied Pipers" in demanding and effecting a reasonable solution to this disgraceful national embarrassment! ■

Doctor Domzalski is a member of the MSMS Committee on Publications.

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Letters from Our Readers

Rackham Arthritis Research Unit article clarified

I read with interest the informative historical summary entitled, "A Look Back at the Founding of U-M's Rackham Arthritis Research Unit," by Joel D. Howell, MD, PhD, (*Michigan Medicine*, January 1989). In the closing paragraphs there are two statements that require some clarification. Doctor Howell stated that the National Institute of Arthritis and Metabolic Diseases was the precursor of the present National Institute of Arthritis and Musculoskeletal and Skin Diseases. This is not strictly the case. The National Institute of Arthritis and Metabolic Diseases subsequently expanded to become the National Institute of Arthritis, Diabetes and Digestive and Kidney Diseases. The National Institute of Arthritis and Musculoskeletal Skin Diseases is actually a new institute that was formed in 1986. Hence, it is the current National Institute of Diabetes and Digestive and Kidney Diseases (NIDDKD) which is the direct descendent of the National Institute of Arthritis and Metabolic Diseases founded in 1950.

Finally, the closing statement in Doctor Howell's article states that the Rackham Arthritis Research Unit receives almost one million dollars per year in federal funds. In fact, the Rackham Arthritis Research Unit currently receives almost $3 million per year in federal funds.

On behalf of the Rackham Arthritis Research Unit, I would like to thank you for publishing Doctor Howell's historical survey.

Thomas D. Palella, MD
Assistant Professor
Chief, Division of Rheumatology
Director, Rackham Arthritis Research Unit
The University of Michigan Medical Center

Transfer of insurance coverage explained

The following is a response to a letter sent by Hira E. Branch, MD, Flint, to MSMS regarding MSMS/Blue Cross and Blue Shield of Michigan health benefits for physicians who retire and move out of the state.

You ask in your letter "Why can't MSMS arrange for a transfer of insurance coverage to Blue Cross Blue Shield in the state to which a doctor moves?" In fact, this can be arranged through a system called "group conversion." A simple form is sent to the physician and after completion, the physician is transferred to group conversion from the date the physician is paid up to in the MSMS group. This prevents any lapse in coverage for the physician and his family. Blue Cross and Blue Shield of Michigan (BCBSM) will continue to bill you until you are covered by your new plan. BCBSM will also send you a postcard with the location of your new plan. Your new plan will contact you about enrollment and benefits. It is important that you keep your BCBSM payments current to avoid a coverage waiting period with the new plan.

A BCBSM underwriting guideline requires that in order to be eligible for coverage, individuals must retain Michigan as their permanent residence. This is interpreted to mean living in Michigan six months a year and having a Michigan mailing address. Members of MSMS who permanently reside outside Michigan are therefore not eligible for the MSMS sponsored BCBSM health care program. This applies to physicians who continue active practice or retire. This policy is consistent with that in effect for other association-sponsored programs.

In order for BCBSM to provide coverage to retirees, the group must meet minimum criteria including:

- Written terms of eligibility for their retirement program.
- A guarantee of payment for the total cost of coverage must be provided.
- The MSMS as well as other associations offering benefits/services to its members do not have a retirement program. Therefore, retirees are responsible for providing their own health care coverage.

As mentioned above, BCBSM does not enroll subscribers whose permanent residence is not in Michigan. BCBSM encourages subscribers who relocate to enroll through the local plan, as it simplifies claims processing and inquiries for the individual subscriber.

I trust the above explanation addresses your questions as to why BCBSM does not offer individual type coverage to non-Michigan residents.

Michael R. Kelly
Chief, Insurance Marketing
MSMS

AMA Medical Student Section establishes fund for students interested in studying abroad

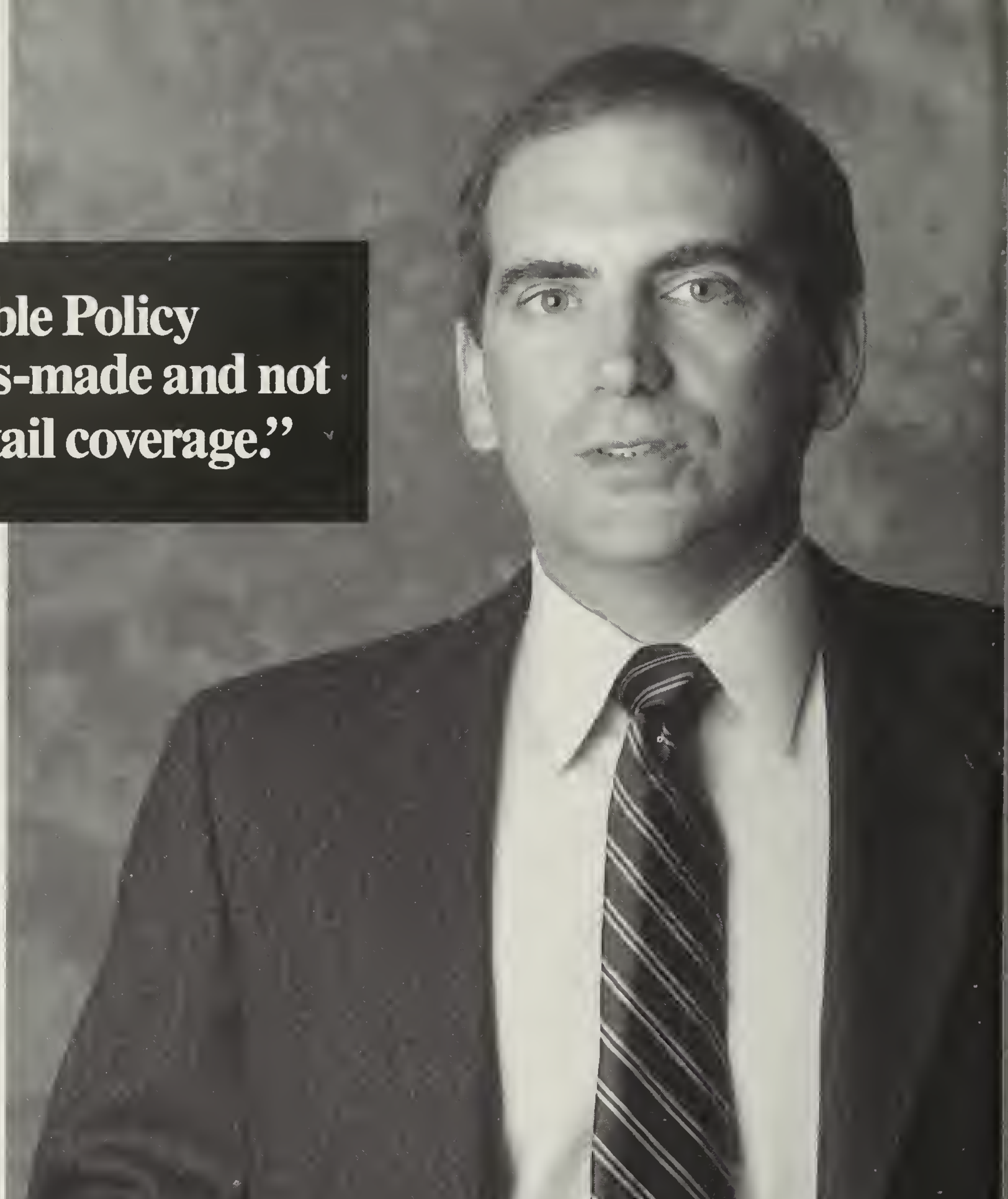
The American Medical Association Medical Student Section has established the AMA-MSS/AMA-ERF International Scholars Fund for the purpose of making grants to medical students who would like to study abroad. Since the establishment of the fund in 1987, medical students have been solely responsible for soliciting donations.

This past December, the Medical Student Section began selling t-shirts to both raise funds for the scholarships and to increase the awareness about AIDS education. The t-shirts are printed with the slogan "Spread the Word, Not the Disease." "AIDS Education: Medical Students Respond," is the national service project of the Medical Student Section initiated 12 months ago that has so far resulted in over 20,000 contacts in communities nationwide. These t-shirts have been useful to medical students who have established educational programs to teach about AIDS prevention and transmission in the communities in which they are working.

The AMA Medical Student Section wants to maximize the publicity given to the t-shirt sale and is contacting both state medical society journals and other organizations in an effort to achieve this goal.

The t-shirts are bright red and are available in sizes large and extra-large. The price for each t-shirt is $10 (including postage and handling). Those interested in purchasing a t-shirt should send a check to the AMA-MSS/AMA-ERF International Scholars Fund, P. O. Box 59473, Chicago, IL 60659.

Howard D. Pomeranz
Chairperson
AMA Medical Student Section
Governing Council



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MEDICAL NEWSFRONTS

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Teen drug use continues decline, U-M survey shows

Drug use among American young people in high school and college continued to decline in 1988, according to the most recent national survey by The University of Michigan's Institute for Social Research. Of particular importance, the downturn in cocaine use, which began in 1987, continued in 1988. And among high school seniors at least, crack use — which leveled in 1987 — also began to decline in 1988.

These are among the central findings of the 14th national survey in the series titled "Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth." (It is also sometimes referred to as the National High School Senior Survey.)

"Nearly all of the changes revealed by the 1988 survey about illicit drug use are good news, particularly those relating to cocaine and crack. There is also some encouraging indication of a decline in alcohol consumption, but unfortunately not much improvement in the smoking rates," said U-M social psychologists Lloyd Johnston, Jerald Bachman, and Patrick O'Malley, who direct the study.

Each year since 1975, some 16,000 to 17,000 seniors in 135 high schools nationwide have been surveyed in the study, which has been funded through a series of research grants from the National Institute on Drug Abuse. Self-completed confidential questionnaires are administered to seniors in their classrooms by U-M research personnel.

Also, each year since 1977, some participants from all previously graduated classes have been followed through the use of mailed, self-administered questionnaires. These follow-up surveys have yielded a representative sample of about 1,200 American college students (one to four years past high school) each year since 1980, and presently yield a national sample of about 11,000 young adults one to eleven years beyond high school.

The detailed findings from the 1988 survey will be published later this year by the National Institute on Drug Abuse as a research

Continued on page 10

Patients needed for study

St. Joseph's Hospital — Macomb

The Neuropathy Institute, St. Joseph's Center for Physical Medicine, is looking for individuals to participate in a neuropathy management program.

Any individuals with tentative or definite neuropathy are being sought for initial evaluation, diagnostic testing, quantification or impairment and subsequent tracking of disease progression. The use of tricyclics for pain control is also being studied and therefore any individual with a painful neuropathy is especially being sought.

For more information, call David S. Weingarden, MD, at (313) 263-2484.

Harper Hospital

A large percentage of the 11 million American adults with diabetes do not respond to the current oral medications or dietary treatment. Harper Hospital is conducting a study involving a drug, metformin, which has been used successfully in Europe and Canada for more than a decade.

Metformin may be an alternative for people who do not respond to the maximum dosage of oral medications. The major benefit of metformin is that is may prevent future insulin use, lower blood cholesterol and possibly cause some people to lose weight.

Harper Hospital is looking for participants between 30 and 70 years of age, at or above their ideal body weight, with type II diabetes (adult onset), who have no other major medical problems.

Interested participants may reach Karen Johnson, study coordinator, at (313) 745-4784, Monday through Friday, 8 a.m. to 4:30 p.m.

Beaumont Hospital

The Clinics of Preventive and Nutritional Medicine, William Beaumont Hospital, are seeking volunteers for a drug study.

Participants in the study must be diabetics who have high cholesterol and who control their diabetes with diet or with oral medications.

For more information, contact the Clinics of Preventive and Nutritional Medicine at (313) 646-6500.

U-M Med Center

The University of Michigan — Section of Orthopaedic Surgery — is conducting a clinical trial of a corrective shoe-orthosis to treat metatarsus adductus in infants two to nine months of age. This study will compare the corrective shoe-orthosis with traditional plaster casting for children with resistant metatarsus adductus.

The Center is recruiting patients with metatarus adductus that has not responded to a preliminary (one month) observation period of stretching. All treatments will be free, and there will be absolutely no cost to the patients for any treatments or radiographs related to the study.

This study is funded by a grant from Camp International and has been approved by the University of Michigan Investigational Review Board.

For more information, or to refer patients to the study, please contact: John E. Herzenberg, MD, assistant professor, Orthopaedic Surgery, University of Michigan Medical Center, 1500 E. Medical Center Drive, Box 0328, Ann Arbor, Michigan 48109-0328, (313) 936-5705.

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monograph, authored by Johnston, O'Malley and Bachman, and tentatively titled "Drug Use, Drinking, and Smoking: National Survey Results from High School, College, and Young Adult Populations, 1975-1988."

Children's health severely at risk, experts say

The status of children's health in America has deteriorated since the late 1970's, after decades of marked improvement, according to a new report, *Profile of Child Health in the US*, released recently by the National Association of Children's Hospitals and Related Institutions (NACHRI).

Local data released by Children's Hospital of Michigan supports the national report's conclusion that the health of American children is severely at risk, and that the children of Michigan are no exception.

"All children should be given the opportunity to achieve," says Paul L. Broughton, president, Children's Hospital of Michigan. "This report indicates that the achievement of our children is compromised long before they enter school, long before they dream of college. Poor health can hinder a child's dream of success faster than any other life circumstances."

Data released by Children's Hospital of Michigan include the following:

- 12 in every 100 births in Michigan are to teen mothers.
- 6.8 percent of all Michigan babies suffer from low birthweight, making them three times more likely to develop a permanent impairment, 40 times more likely to die in the first month of life and 20 times more likely to die in the first year of life.
- Michigan's infant mortality rate is altogether too high, with 11.4 infant deaths per 1,000 live births, making it higher than that of most modern European countries.

The *Profile of Child Health in the United States* was compiled by experts in pediatric medicine, nursing, social work and child health programs. "Through the investigation of 13 'health indicators,' the *Profile* reveals a disturbing picture of children's health in the 1980s," says Children's Hospital associate administrator Doris England, chairperson of the Council on Child Health. "Here in Detroit, we are especially troubled by inadequate prenatal care which can result in low birth weight babies. We see children like this every day — children whose fate could have been otherwise, if forward thinking health policies were in place."

Drug may end childrens' fight against infections

Children facing an uphill — and sometimes impossible — struggle with recurring bacterial infections may soon find some relief, thanks to a growth hormone developed from bone marrow.

An experimental drug being tested at the University of Michigan and seven other medical centers is stopping a rare and sometimes fatal blood disorder that makes it difficult for affected children to fight off infections.

The drug, a bone marrow hormone that has been cloned and purified, stimulates production of white blood cells in children born without the ability to make normal numbers of these cells. White blood cells are needed to protect the body against bacterial infection.

Before antibiotics were available, many of these children died in infancy from overwhelming infection. But even antibiotics cannot halt the disease, called severe congenital neutropenia.

The disorder results in recurring infections, such as pneumonia, lymph gland infections, skin infections, liver abscesses and severe gingivitis or periodontal

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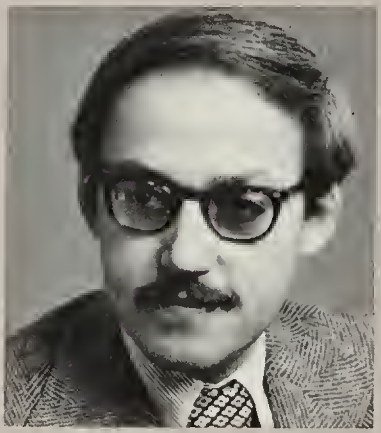
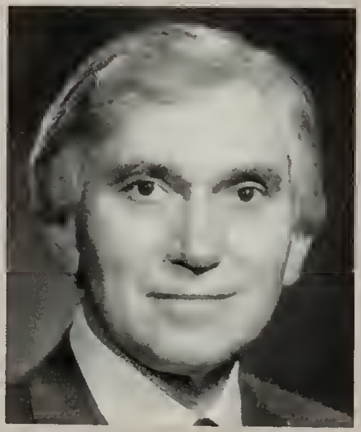
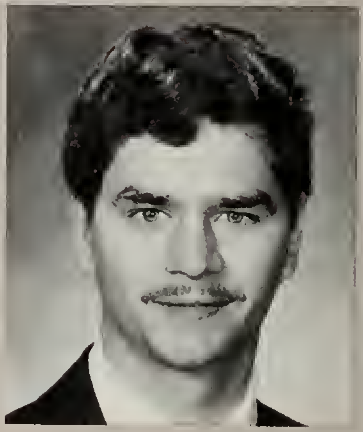
Physicians in the News



John J. Voorhees, MD, Ann Arbor, professor and chairman, Department of Dermatology, University of Michigan Medical Center, is the new president-elect of the Association of Professors in Dermatology (APD). Doctor Voorhees, who has been a member of the organization for 14 years, will serve a four-year term. The national organization is for all the chairmen of departments and divisions of dermatology with residency training programs in the United States. Its objective is to promote medical education, research and patient care, particularly in undergraduate and graduate dermatology training programs.



Sid Gilman, MD, Ann Arbor, professor and chairman, Department of Neurology, University of Michigan Medical Center, is the new president of the American Neurological Association (ANA). The ANA is the oldest neurological society in the world. Doctor Gilman is the immediate past president of the Michigan Neurological Association and is a member of the Governor's Chronic Disease Advisory Board. He came to the U-M 11 years ago to serve as professor and chairman of the Department of Neurology.



Karl J. Edelmann, MD, Ann Arbor, a senior resident at the University of Michigan Family Practice Residency Program and longtime Republican activist, is a new-elected member of the Second Congressional District Republican Executive Committee. Doctor Edelmann, who will open a new family practice office in Ann Arbor July 1, says, "Being active in politics is really just an extension of why I am a physician, to serve people." He will serve a two-year term.

Jack Ferlinz, MD, West Bloomfield, is chairman, Department of Medicine, Providence Hospital, Southfield. He was previously chairman of the division of cardiology and professor of medicine at Cook County Hospital, Chicago.

Steven Minnick, MD, Grosse Pointe Park, director of Health Education for St. John Hospital and Medical Center, now represents the hospital as a leader in three organizations involved with graduate medical education at the state and national level. He was recently elected president of the Michigan Association of Medical Education (MAME). He's been an active member of the group since 1982, and will assume his new role in May 1989. He is currently secretary/treasurer. The Michigan State Medical Society (MSMS) has appointed Minnick as an alternate delegate to represent MSMS on the Michigan Council of Graduate Medical Education. The Association for Hospital Medical Education has him as its Regional IV chairman. Region IV encompasses Michigan, Wisconsin and Minnesota. The prime purpose of these organizations is to provide a forum for communication about issues, concerns, ideas and standards for medical education. Doctor Minnick joins other representatives from teaching hospitals and universities who strive to provide high quality medical education programs. He also maintains a private internal medicine practice.

Stewart E. Pursel, MD, Southfield, is the new chief of thoracic surgery, Surgical Services Department, William Beaumont Hospital, Royal Oak. He joined the Beaumont medical staff in 1978 after serving as chief of Thoracic and Cardiovascular Surgery at both Harper and Sinai hospitals in Detroit. He is a fellow of the American College of Surgeons and the American College of Chest Physicians and is certified by the American Board of Surgery and the American Board of Thoracic Surgery.

Marjorie Peebles-Meyers, MD, is a member of the Board of Trustees, Detroit Receiving Hospital and University Health Center. She recently retired from Ford Motor Co., where she served as physician in charge of the medical units at World Headquarters and Ford Motor Credit Co. She retired in 1985. A graduate of the Wayne State University School of Medicine, Doctor Peebles-Meyers was the first black woman to graduate from the medical school. She also was the first black woman to serve as intern and resident at Detroit Receiving Hospital.

Norman Krieger, MD, a long-time Milford resident, has been named "Physician of the Year" for 1988 by the medical staff at Huron Valley Hospital. A Milford internist since 1960, Doctor Krieger serves as chief of staff on the Medical Executive Committee and is a member of the Huron Valley Hospital Planning Committee.

Jerome E. Seymour, MD, is president of the Midland County Medical Society for 1989. Other officers are Winifred A. Oyen, MD, president-elect; and Nicholas J. Ivan, secretary/treasurer.

Gauis D. Clark, MD, director of emergency services at St. Lawrence Hospital, Lansing, is the hospital's new chief of staff. His two-year term was effective January 1.

Continued from page 10

problems. Many children lose their teeth by adolescence.

But in the multicenter study, injections of the drug Granulocyte-Colony Stimulating Factor, or G-CSF, have proven effective in reversing neutropenia.

In persons with neutropenia, the neutrophils, or granulocytes — the white blood cells that attack and destroy harmful bacteria in the body — fail to mature and differentiate in the bone marrow. Because there are fewer white cells, infections persist.

G-CSF stimulates the precursor, or parent, cells of the neutrophils to divide and mature into neutophils, which raises the body's white cell count to a normal level.

"We are seeing children from all over North America who are coming to the U-M Medical Center for treatment," says Laurence Boxer, MD, professor, pediatrics and communicable diseases, and chief, Pediatric Hematology/Oncology at the U-M Medical Center. "I can tell people with certainty that they are going to respond to treatment and turn their lives around. All the patients who have been treated have recovered. The treatment is that effective."

The U-M Medical Center has joined Memorial Sloan-Kettering in New York City; St. Jude Children's Research Hospital in Memphis, Tenn.; UCLA; the University of Washington in Seattle; the University of Colorado; Emory University Hospital in Atlanta, Ga.; and Duke University Hospital in Durham, NC., in treating patients with G-CSF.

The Food and Drug Administration classified the drug as experimental in November 1988 after four years of animal research involving primates and the great collie, a homologue animal model that exhibits the same problems as humans suffering from neutropenia.

Only the U-M Medical Center, Memorial Sloan-Kettering and St. Jude are treating children, with most pediatric referrals coming to C.S. Mott Children's Hospital at the U-M Medical Center. Other forms of neutropenia — ideopathic (the origin is unknown or uncertain) and cyclic (a rare form in which patients become neutropenic for several days and then recover) — also are being treated.

Results of the studies being conducted across the country will be submitted to the FDA in the next year. If approved by the FDA, the drug will be available for general use by hematologists in two to six years.

Japanese firm gives WSU $725,000 grant

With a $725,000 grant from Ono Pharmaceutical Co. of Osaka, Japan, three Wayne State University researchers will study inhibitors of an enzyme that may be linked to the spread of cancer.

"The grant is for a five-year period and the first year of funding is $725,000," says Carl Johnson, WSU chemistry professor. Doctor Johnson will work with WSU faculty members Lawrence J. Marnett, chemistry professor, and Kenneth V. Honn, professor of radiation oncology and adjunct professor of chemistry. This is the first major grant made by Ono Pharmaceutical Co. to an academic institution outside of Japan.

The research will focus on inhibitors of the enzyme 12-lipoxygenase. "The enyzme produces a substance from the common unsaturated fatty acid known as arachidonic acid," Doctor Johnson explains. "This substance is involved as a biological control agent in many processes, including the possibility that it plays a significant role in the metastasis of cancer." This possible connection is a major factor in the interests of the investigators and the Japanese company.

The three investigators and WSU Vice President for

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Research Garrett Heberlein met with representatives of the company, Akiyoshi Kawasaki, director of Ono Research Institutes, and Yoshitaka Kimura of International Product Development, at Wayne State, to formulate this new initiative.

MSU teleconference to address needs of elderly

A national teleconference — to originate at the Michigan State University (MSU) television studios in East Lansing Nov. 1 — will focus the attention of health professionals on a group of Americans who are, and will continue, making history.

By the year 2000, elderly Americans will make history by taking over the top spot as the largest population segment in the nation. By that time, elderly Americans, already the fastest growing segment, will comprise nearly 40 percent of the US population.

That growth is giving rise to new concerns about the special health and nutrition needs of the elderly. The upcoming teleconference is designed to help health professionals who work with the aging population to address some of the special needs of this group. Those needs include health fraud, use of prescription drugs, nutrient needs, factors influencing food intake, and special problems of elderly minorities.

More than 200 downlink sites will receive the live broadcast of the teleconference. Speakers will also field questions from viewers nationwide.

Continuing Medical Education Credits will be available for health professional groups, including physicians, dietitians and home economists.

Co-sponsoring the event are the Geriatric Education Center of MSU; the Food and Drug Administration in Detroit; Department of Family Practice, College of Human Medicine, MSU; Division of Broadcasting Services, MSU; and Dairy Council of Michigan.

New computer system can track tumors

Doctors at Henry Ford Hospital now have a computer system that gives them three-dimensional images of brain tumors. The computer — one of the few systems of its kind in the world — allows surgeons to track the exact location and size of a tumor.

The computerized system, called image guided stereotaxic planning, is a form of tomography. Traditional tomography is a type of X-ray that shows cross sections of the brain. Using the new system, a headframe connected to a computer scanner is placed on the patient's head. The computer provides three-dimensional images of the tumor in color. They can be rotated to any viewpoint. Doctors then plot coordinates on the computer to tract the exact location and size of the tumor.

Normally, tumors are treated through laser surgery or radiation. With the information doctors receive through the new tomography system, they are able to program the laser or radiation devise to the exact location of the tumor, minimizing potential damage to surrounding healthy tissue. The system also tells how much radiation is needed.

Doctors hope image guided stereotaxic planning soon can be applied to other areas of medicine, including orthopaedics and otolaryngology. For example, using the new tomography system on the spine may help doctors develop treatments for certain back disorders.

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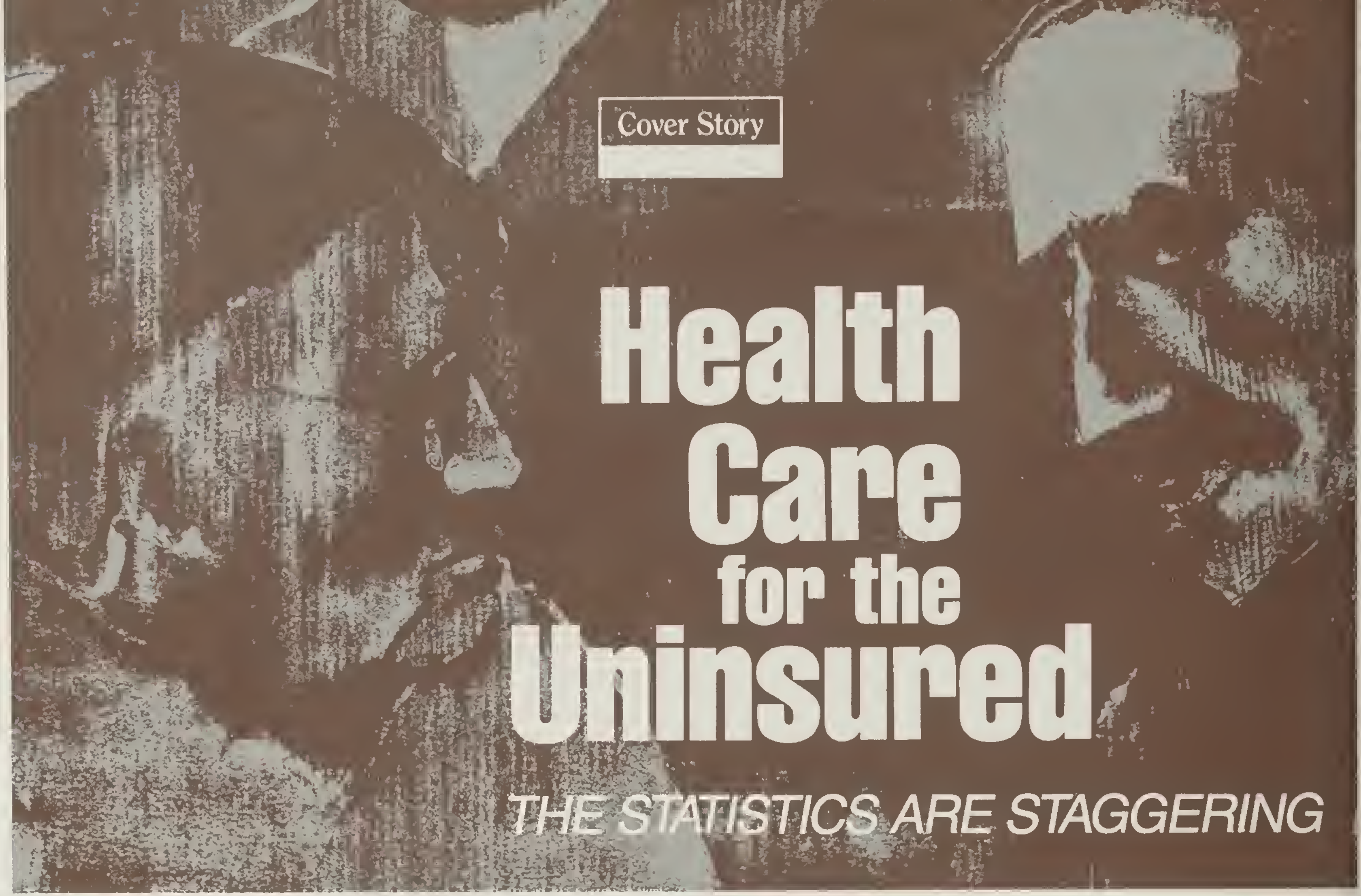


Cover Story

Health Care for the Uninsured

THE STATISTICS ARE STAGGERING

By Marguerite Shearer, MD

Access to health care — the statistics are staggering, the consequences devastating and the solutions not easily found.

Over 37 million Americans lack coverage for health care. In Michigan, one million residents are without any form of health insurance. The demographics of Michigan's uninsured population parallel those of the rest of the country. Over one-third of our country's uninsured are from families with incomes at or below poverty level; an additional 30 percent have incomes from 100 to 200 percent of poverty level. In Michigan, as in the rest of the country, the overwhelming majority of our uninsured are children and young adults.

As the number of people caught in the gap between government sponsored health programs and private insurance grows, so does its impact on our health care system. Hospitals and physicians, once able to subsidize their cost of caring for the uninsured, are now absorbing these costs through uncompensated care. In 1986, Michigan hospitals provided $239.3 million in uncompensated care; nationally, $12.9 billion of care went uncompensated.

The financial gap between the insured and uninsured is creating a gap in their health status. Infant mortality, due to lack of prenatal care, is perhaps the most dramatic consequence of the gap. Discouraged by their inability to pay, many uninsured delay needed preventive and diagnostic services, until they need emergency or acute care. The end result is, of course, that the uninsured often consume the most intensive and extensive medical care available.

In the 1960s, the need to address health care for the poor was driven primarily by social policy. Today, we are confronted by economic pressures as well, and the balance between assuring access and controlling costs is not readily available.

Difficult decisions ahead

A review of the many proposals at the federal level, and in states across the country, suggests difficult decisions will need to be made in responding to the challenge of access to health care. Federal and state proposals to mandate employer-paid insurance face an uphill political battle, due to stiff opposition from the business community and the questionable impact of such programs in closing the gaps in our health care system. Expansion of government sponsored programs, including Medicaid and public health, is forcing difficult decisions about government spending priorities, and the allocation of limited resources.

In Oregon, a response to the health care access crisis led the state to discontinue public funding for heart, pancreas, bone marrow and liver transplants, and redirected those funds to extend preventive and prenatal benefits to a larger group of uninsured people. This explicit rationing decision is demonstrative of the difficult ethical, clinical and political decisions that will need to be made in the years ahead.

Mandated employer-paid health insurance is under study at the federal level, and also has been enacted in some states, most notably Massachusetts. An analysis of a federal health insurance plan, modeled after the Massachusetts program and introduced by Senator Edward Kennedy (D-Massachusetts) and Representative Henry Waxman (D-California), finds that the plan would cover 22 million employed uninsured workers and their dependents nationwide — leaving at least 15 million without coverage. The Kennedy-Waxman Bill, and similar proposals in state legislatures, face strong opposition from the business community, and mandated health insurance may ultimately become part of a broader resolution to address the needs of the uninsured.

Funding alternatives

Many states are looking at increased

taxes to provide revenue for publicly-funded programs for the uninsured. California has enacted an increased cigarette tax, with the revenues initially targeted for indigent care. Other states — Florida, New Jersey and Iowa — have indigent care funds financed through assessments and surcharges on hospitals and insurers.

Expansion of Medicaid eligibility and permitting the uninsured to purchase Medicaid coverage are options under active consideration. A recent report of the Health Policy Agenda for the American People's Ad Hoc Committee on Medicaid suggests expansion of the Medicaid program to provide a basic set of benefits to a broader group of poor and near-poor than the program currently permits. (An indepth article on the Committee's recommendations appears on page 16.) Expanded Medicaid eligibility has been enacted in Michigan and elsewhere as a response to the infant mortality crisis; pregnant women with incomes at or below 185 percent of the poverty level are now eligible for Medicaid coverage, in an effort to encourage needy women to seek early prenatal care.

National attention is also being directed toward a universal health insurance plan. Recently, the National Leadership Commission on Health Care — co-chaired by former Presidents Carter, Ford and Nixon — recommended the establishment of basic benefit requirements for all private insurance plans and the creation of a publicly-funded benefits program called the Universal Access Program. The program would be financed through assessments on employers not providing health coverage and on individuals with incomes above 150 percent of poverty level.

A plan for Michigan

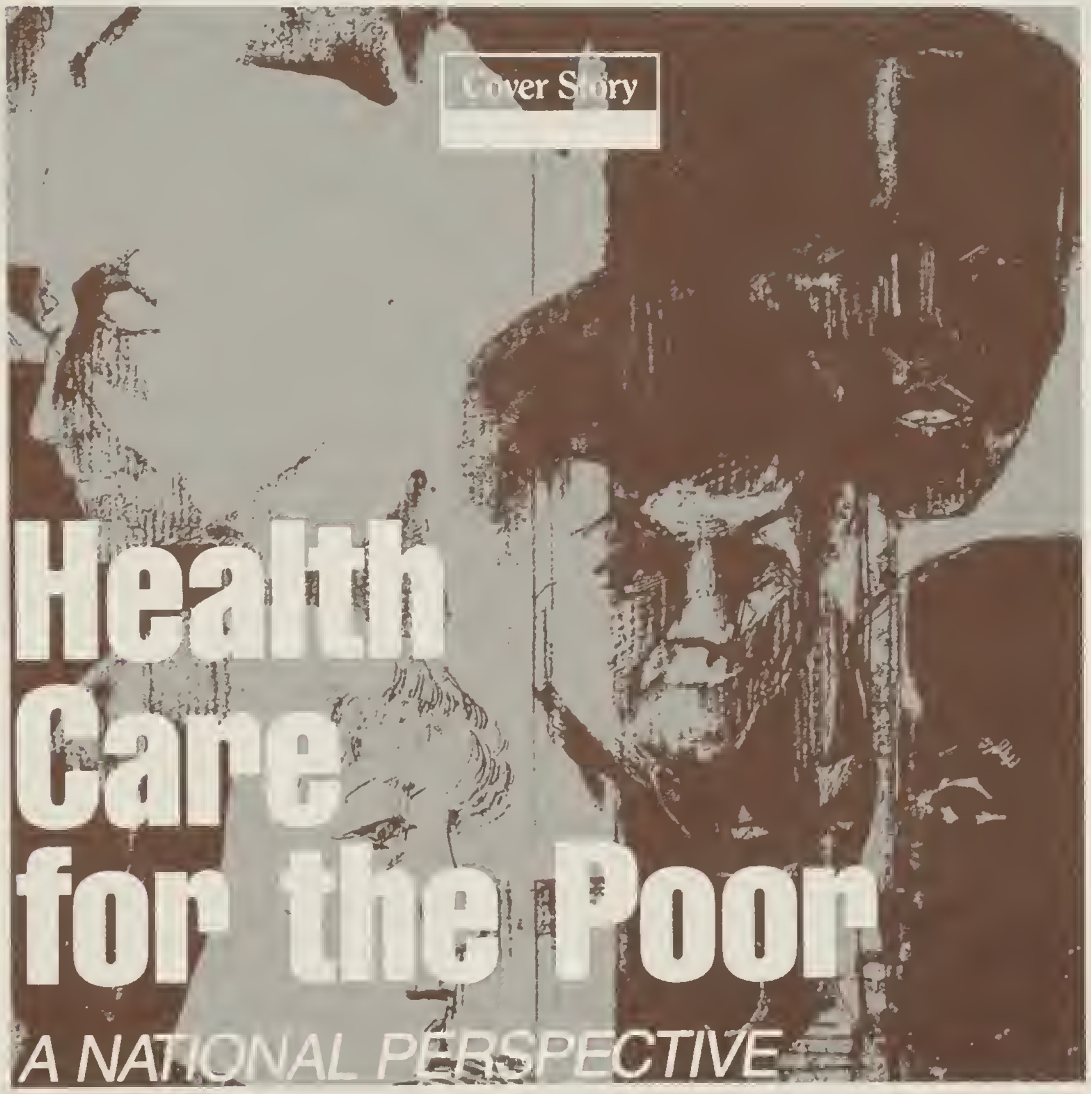
In Michigan, a gubernatorial task force is exploring alternatives to assure access to health care, and a pilot project — funded through the Robert Wood Johnson Foundation — is underway. The Governor's Task Force on Access to Health Care — a 40-member group consisting of providers, business, labor, state government and human services advocates — began meeting in September 1987 and plans to make recommendations to the Governor this September. The Task Force is concentrating its efforts on health care for individuals — both employed and unemployed — with incomes at or below 200 percent of poverty level.

As the Task Force prepares to develop its recommendations, research is underway on a number of program options, ranging from revisions to the state's tax policies to provide insurance incentives to the creation of a universal health system for Michigan. Any recommendation of the Task Force will be subject to legislative approval. It certainly will be 1990 before Michigan has a system to provide health care for the uninsured.

Included in this cover story are: information on the Health Policy Agenda for the American People's recommendations on health care for the poor; an article about Michigan's Health Care Access Project; a review of program options under study by the Governor's Task Force on Access to Health Care; and a feature about some Michigan physicians who are voluntarily providing health care for the uninsured. These provide just a glimpse of the many proposals that will surface — and the many efforts underway — as the debate over access to health care continues.

These are difficult problems with complex solutions. The failure of Medicaid and Medicare to fully address access needs, and the drive to control health care costs, suggest we must cautiously review any and all proposals designed to respond to the health care access crisis. The solution cannot rest solely with the government, nor can it rest solely in the private sector. MSMS and the AMA will continue to work in partnership with government and business to address the challenge of access to health care. ■

Doctor Shearer is MSMS representative to the Governor's Task Force on Access to Care, and is a member of the MSMS Board of Directors.



Health Care for the Poor

A NATIONAL PERSPECTIVE

Editor's Note: *The Health Policy Agenda for the American People (HPA), a coalition of 172 public and private sector organizations, was established in 1982 by the American Medical Association to address America's long-term health care policy needs and to create a framework for future direction. The HPA identified expansion of Medicaid as one of the nation's most urgent health care issues. To address the question of how change should occur, the HPA Implementation Committee appointed an Ad Hoc Committee on Medicaid comprised of experts conversant with all aspects of its problems. The following article presents the Committee's findings and recommendations regarding Medicaid and has been taken verbatim from the Committee's report,* ***Including the Poor****, published in February 1989.*

Story begins on page 16

Continued from page 15

Medicaid, the nation's major program to provide health care to low-income persons, is failing to address the health care needs of the poor. Even though the number of the poor without access to health insurance has grown over the past decade, 11 million persons with incomes below the federal poverty level were without any health insurance in 1988, and over 50 percent of the poor did not qualify for Medicaid.

Although a patchwork of charity care and publicly funded delivery systems is available to some individuals in some communities, this incomplete system does not ensure access to comprehensive and consistent care for all who need it. A 1986 survey discovered that 19 million Americans encountered difficulty in obtaining health care due to financial reasons, and an estimated one million persons were denied care because they were unable to afford it.

The failure of the program to provide comprehensive access for the poor lies with its rules governing eligibility, benefits and reimbursement. The Medicaid program is unlike the Medicare program, which has a national eligibility standard, a uniform benefit package and a national standard for reimbursement. Rather, rules governing access to Medicaid services are generally left to individual states to define.

Qualifying for Medicaid is strongly linked to eligibility for public assistance programs, with individual states having discretion to establish income eligibility standards for the majority of Medicaid recipients. The result is significant variability in eligibility from state to state. For example, a family of three living in Utah can earn $8,316 and qualify for Medicaid; but if the same family moves to Alabama, where the income eligibility criterion is $1,416, it will be denied Medicaid benefits.

Even for those persons who do qualify for Medicaid, the provision of health care services will also vary because states have the authority to define the scope of specific services available to Medicaid recipients. For example, states can limit the number of inpatient hospital days for which Medicaid will pay. Some states also place annual limits on the number of physician office visits covered.

This absence of national standards governing the Medicaid program means that access to Medicaid services is determined not by individuals' needs for health care but rather by states' financial capabilities and levels of political commitment. If Medicaid is to provide comprehensive access to services for the poor, it must be reformed so as to correct these variations.

Eight major reforms needed

To help achieve this goal, the Health Policy Agenda Ad Hoc Committee on Medicaid recommends eight major reforms that are necessary if the program is to be effective:

1. The Medicaid program should be restructured so as to be governed by national standards and goals.
2. The categorical link of Medicaid eligibility to public cash assistance (welfare) programs should be broken; and income eligibility for the program should be set at no less than the federal poverty level.
3. All states should be mandated to adopt a Medically Needy program with "spend down" eligibility provisions. Asset testing should be acceptable as an eligibility requirement only under the Medically Needy provisions. "Medically Needy" persons are those whose incomes exceed the Medicaid eligibility level but who have been impoverished by catastrophic medical bills.
4. A standard benefit package should be provided by each state and it should be federally mandated. It should include:
   - ■ Physician services
   - ■ Inpatient and outpatient hospital services
   - ■ Laboratory and x-ray services
   - ■ Prescription drugs
   - ■ Institutional care for the elderly and the physically or mentally disabled
   - ■ Dental services
   - ■ Early and periodic screening, diagnosis and treatment (EPSDT) services
   - ■ Family planning services
   - ■ Home health and personal care services
   - ■ Other medically necessary professional services
5. Medicaid expansion should include measures to promote cost-effective delivery of services.
6. Medicaid expansion should include policies and incentives to encourage broader health care provider participation.
7. A greater burden of the fiscal impact of eligibility expansion should be borne by the federal government. At the same time, the federal formula governing reimbursement to states should be revised to correct for tax burden inequities.
8. Long-term care services should be continued under Medicaid or through a structurally improved program.

Reforms will be costly

The cost of these revisions will be significant and is expected to range from approximately $13 to $28 billion beyond current expenditures for the Medicaid program. The most significant factor explaining this spread is the type of benefit package that will be selected.

To establish Medicaid eligibility standards at the federal poverty level will cost approximately $9 billion. But some of the cost of this expansion can be expected to be offset by reductions in spending elsewhere in the health care system. By factoring in reductions in spending for uncompensated care that is now delivered by health care providers and state and local governments, as well as the out-of-pocket expenses of the poor, the net cost in terms of total social spending would be about $2.3 billion.

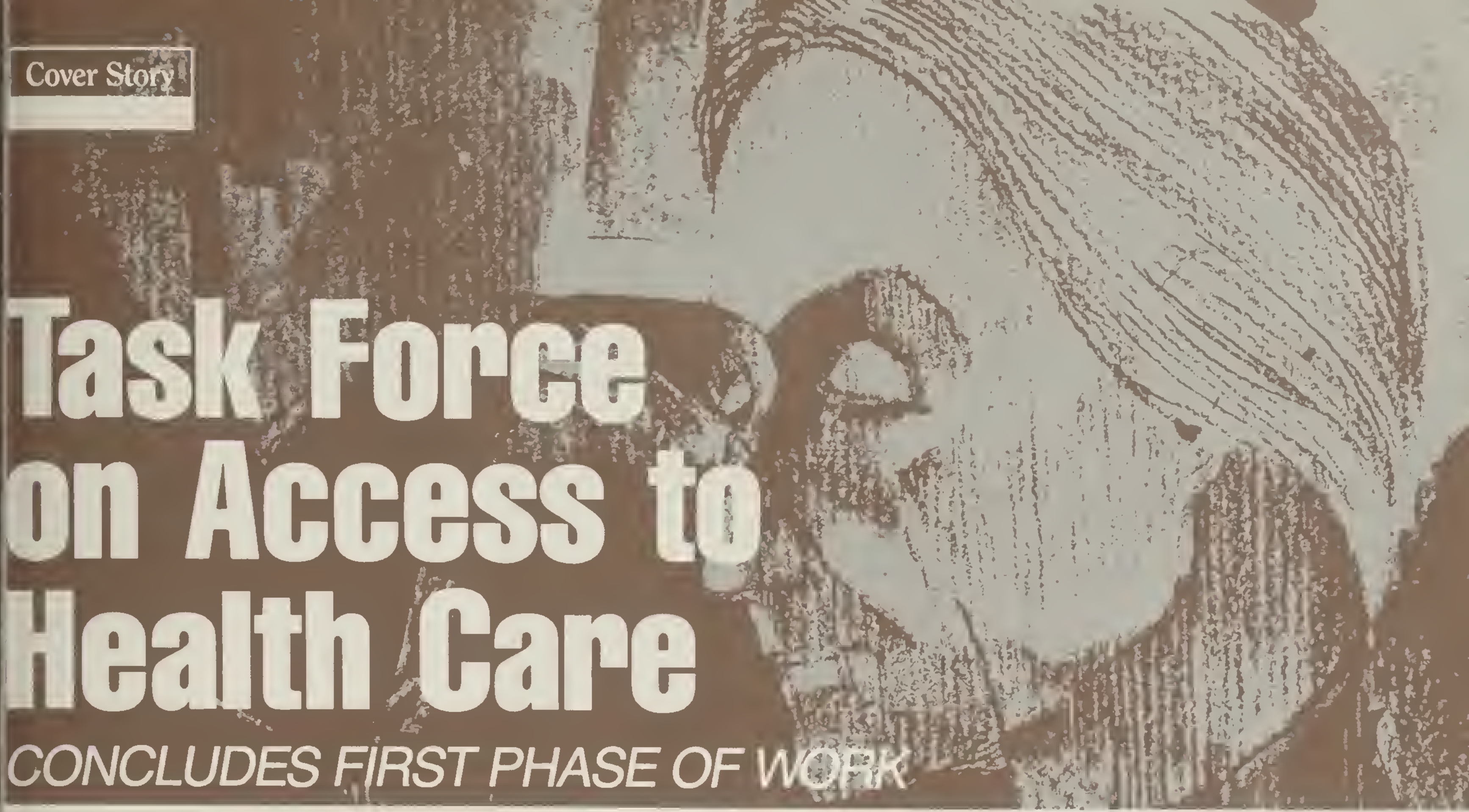
The establishment of a uniform benefit package that provides a median level of comprehensiveness would require an additional $6.5 billion. Should a more comprehensive benefit package be provided, the cost would be expected to be as much as an additional $21.5 billion. Finally, enhancing the rates of reimbursement for physicians and hospitals providing Medicaid services would require approximately another $4.4 billion.

The failures of the present Medicaid program are such that they will continue to burden the health care system with rising uncompensated care costs, and will continue to restrict access to care. Much of the current national debate on health care policy focuses on money: the problems of an ever more expensive system, the need to constrain costs, and the way in which the bills should be paid.

Issue goes beyond money

These are real problems. But a dialogue about money alone overlooks the American commitment to assuring access to care for all. If we fail to acknowledge that commitment, it is easy to fail to include the poor in the health care financial equation. Such discussions exclude the poor from the debate just as they too often are excluded from the health care system.

The Committee has begun to identify the fundamental objectives that a rebuilt Medicaid program should achieve, and also to specify basic changes in its structure that are necessary for it to reach its legitimate goals for all those under the poverty level who have no coverage. ■



Task Force on Access to Health Care

CONCLUDES FIRST PHASE OF WORK

A 40-member Task Force was appointed by Governor Blanchard in September 1987 to develop recommendations for providing health care to Michigan's one million uninsured citizens. The Task Force on Access to Health Care has concluded the first phase of its work by identifying: (1) systemic problems that restrict access; and (2) target populations for its efforts.

The Task Force is currently reviewing several program options and will be finalizing its recommendations in September. A list of program options under consideration follows.

Tax credits or deductions. A broad-ranging approach that restructures tax policy to create incentives for businesses or individuals to purchase health care coverage.

State subsidies. An approach that recognizes the economic constraints for individuals and employers. State subsidies could be a way of lowering premium costs for groups as a whole or for low-income individuals (e.g. Michigan's HCAP). Subsidies could be in the form of services or direct cash payments to the buyer.

Mandated coverage. An approach mandating coverage through the private (employers, third party payers and individuals) or public sector. Benefit package may be comprehensive, limited or catastrophic. Employers might be required to offer health coverage to employees (e.g. Massachusetts, Hawaii), spouses or dependents. Third-party payers could be required to offer coverage to all individuals or small businesses. Individuals might be required to carry catastrophic coverage or to carry coverage for spouses and dependents. Public coverage would require the state to offer a basic package to all citizens.

Medicaid and GA options. Medicaid is a joint state and federal categorical program that provides services to categorically defined individuals who meet income and asset requirements. Therefore, options might range from expanding existing categorical groups to adding new categories, allowing buy-in and providing transitional coverage for assistance clients who are newly employed.

General assistance is similar to Medicaid but is entirely state-funded and covers other groups.

Insurance pools. An option to maximize the advantage of large groups in obtaining coverage. Programs could include high risk pools, multiple employer trusts and statewide pools for individuals.

Policies offered by third party payers. An approach that would require that non-government third party payers doing business in Michigan offer a defined benefit package.

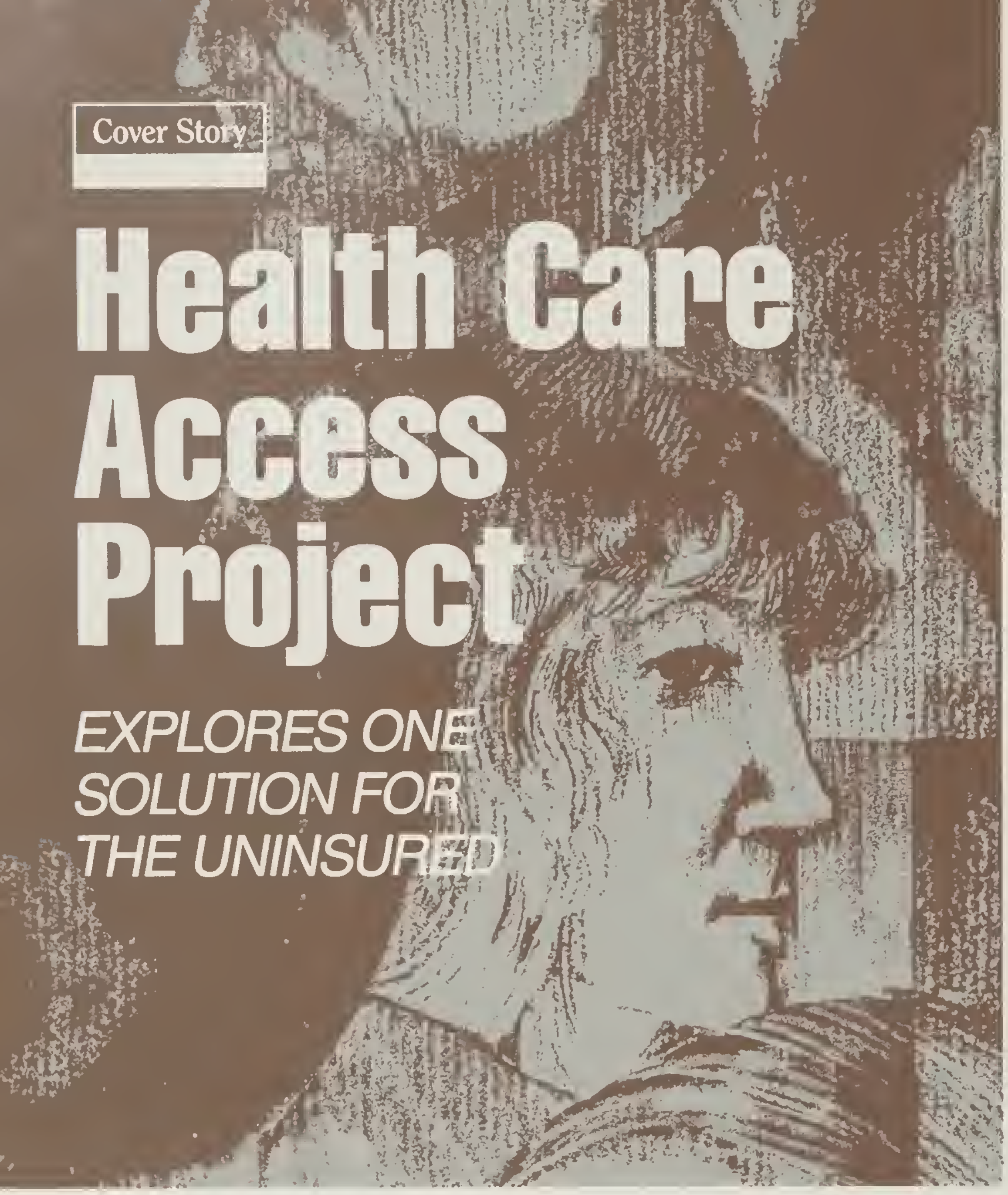
Regulatory. This approach relies on the regulatory authority of the state and may compel providers to render a defined level/quantity of services either as a condition of licensure or of doing business in Michigan.

Reimbursement for uncompensated care. An option addressing the problem from the provider perspective. Programs could range from creating health programs for the noncovered population to reimbursing providers for costs or for bad debts. These programs already exist in some form.

Direct funding of providers of last resort. An approach wherein state and local governments assume responsibility for providing care. Strategies range from state funding and operation of hospitals to assigning full responsibility to counties.

Targeted public programs. A public sector approach directed at limited populations or to individuals with specific medical problems. Programs range from direct delivery of services to cash assistance for purchase of private services.

Changes in existing programs. Ongoing review of existing programs by the committees of the Task Force should result in recommendations to improve access. ■



Cover Story

Health Care Access Project

EXPLORES ONE SOLUTION FOR THE UNINSURED

By Vernon K. Smith

A two-county demonstration project in Michigan is testing an innovative approach to addressing health care for the uninsured.

The *Health Care Access Project* (HCAP) will determine the extent to which subsidizing the employer's health insurance cost will increase the number of persons with employer-based insurance.

HCAP also seeks to increase the chances that a welfare recipient will get a job that offers health insurance.

The *Health Care Access Project* is a major project under the Robert Wood Johnson Foundation's *Health Care for the Uninsured* program. Administrative costs are funded by an award from the Robert Wood Johnson Foundation to the Michigan League for Human Services. Financial support for medical care is provided by the Charles Stewart Mott Foundation, the Michigan Department of Social Services and Genesee and Marquette Counties.

In addition, a number of others have supported and participated in HCAP, including the Michigan State Medical Society, the Michigan Hospital Association, the Michigan Primary Care Association; as well as local hospitals, physicians and the Chamber of Commerce.

Although the project has operated for only about a year, early indicators show that the primary purposes of the project are being accomplished. These purposes include the following:

- To decrease the number of persons without health insurance.
- To decrease dependency on welfare.
- To increase access to health care for persons on welfare.

The "one-third" share plan

The most visible feature of HCAP is the "One-Third Share" (OTS) Plan. Under the OTS plan, the project is able to pay one-third of the cost of health insurance for a small business. The employee and the employer each pay a third of the cost as well. The subsidy is available for employees whose wages are below 200 percent of poverty.

As originally implemented, the subsidy was available only to businesses which hired a welfare recipient. Later, this requirement was modified for a one-time 90-day open enrollment period which ended in December 1988.

As of April 1989, a total of 103 businesses were participating in the OTS plan. These included 33 in Marquette County and 70 in Genesee County. The average participating business has been between five and eight employees. Thus, through this project, employer-based health insurance has been offered for the first time to some 600 employees and their dependents.

New medical I.D. card

A significant but less viable part of the project involves a new health care delivery system for persons on welfare.

Prior to HCAP, persons on "General Assistance" welfare would obtain ambulatory care only by first obtaining a service-specific authorization from the local department of social services. For every individual service, the recipient had to get a caseworker-issued authorization form before going to the doctor, dentist, pharmacy or other provider. It is a cumbersome system that, by its structure, discourages a recipient from seeking care. In inpatient hospital services, the recipient had to apply separately to the county hospitalization program.

Under HCAP, this "non-system" was replaced with a single program which provides a combined ambulatory and inpatient hospital benefit. A recipient receives a medical identification card similar to a Medicaid card. The card replaces the service-specific authorization system and allows providers to bill for services with greater certainty of payment.

Significantly, to encourage physician participation, physician reimbursement was changed from GA Medical rates to Medicaid rates, an 18 percent increase.

Managed care delivery system

To ensure a cost effective program, a managed care delivery system was implemented. In both Genesee and Marquette counties, a "Physician Sponsor Plan" approach, similar to the Medicaid *Physician Sponsor Plan* in Wayne County, is used. All GA recipients are required to enroll with a physician sponsor, who provides or authorizes all health care for that recipient. In Genesee County, recipients have the choice of either a physician sponsor or HMO.

Continued coverage

To improve the chances that a recipient will "work his way off of welfare," the project provides transition health coverage. Under this provision, the project continues the HCAP benefit for four months after a recipient gets a job and leaves assistance. This four month coverage is intended to give the former recipient time to qualify for his new employer's health coverage, where the employer already offers health insurance, or, where the employer does not offer health insurance, it provides HCAP marketing staff the time to work with the employer to see if health insurance can be initiated through the One-Third Share Plan.

The importance of this transition coverage is underscored by DSS statistics which show that a recipient who leaves assistance to take a job without health insurance is more than twice as likely not to have that job six months later, when compared to a recipient who took a job with health insurance. Often times, those who lose or leave their jobs end up back on public assistance.

New eligibility

Finally, the project includes a new eligibility category for persons with medical needs who can't qualify for Medicaid, even though their income and assets would qualify them under Medicaid limits. Typically, these are single individuals or childless couples who cannot qualify for Medicaid because they are not aged, blind, disabled, or have dependent children, which are required characteristics for Medicaid eligibility.

Lessons learned

It is too early to fully access HCAP. Still, the experience of the first year suggests important conclusions:

- Small business owners will buy health insurance when the cost is reasonable. The fact that over 100 businesses initiated insurance in the first year established this fact.
- Many employers who work in small businesses that do not offer health insurance are insured. In fact, about 40 percent of employees in businesses who began offering insurance through HCAP were already insured as a dependent on a policy carried through another employer. In effect, businesses offering health insurance now are subsidizing those who do not offer insurance.
- However, the affordability of health insurance is still the single most important barrier to initiating health insurance. Of the qualifying businesses contacted by HCAP marketing staff, over half chose not to participate, even at the discounted rate available through the project, because they said the premiums were too costly for them.
- Health care access is improved through the medical I.D. card system, when compared to the previous service authorization system. In fact, preliminary data show that under HCAP, eligible welfare recipients were about 40 percent more likely to obtain one or more health care services.
- There are many persons with medical needs who can't qualify for Medicaid or any public assistance. In the first year, the program provided health coverage for almost 700 such persons. For a large proportion, the needed care required an inpatient hospital admission. The number of hospital admissions increased by threefold. For hospitals, HCAP coverage may have reduced the extent of uncompensated care.
- Medical costs have increased as caseloads, utilization, payment rates and access have increased under the project.

There are lessons yet to be learned from HCAP. For example, we are learning what happens when a subsidy is offered, but we are still to learn what happens when a subsidy ends. We also need to see the extent to which the increase in costs is the result of a pent-up demand, which may return to a lower level over time. The effect of managed care, and the effectiveness of transition health coverage on employment are other features which will require more time to evaluate.

Policymakers will be examining the HCAP experience to determine if this is the appropriate model under which health care should be provided for the indigent in Michigan. ■

Vernon Smith is deputy director, Medical Services Administration, Michigan Department of Social Services.

DATA SHOW LACK OF INSURANCE A SERIOUS PROBLEM

By Vernon K. Smith, PhD

Most Michigan residents — about eight out of nine — have some kind of health insurance coverage.

However, a significant and growing segment of our population has no health coverage. In fact, over one million persons in Michigan — about 11 percent — are not covered by any health plan at all. They have no employer-related program, no Medicare, no Medicaid, no health care program or insurance of any kind. Nationally, the statistics are worse; over 37 million — or 18 percent — of all Americans are uninsured.

The number without health insurance is growing. The likelihood of being without health coverage is about 25 percent greater now than it was in 1980.

Recent evidence suggests that the primary consequences of being uninsured is that people do not seek or get medical care that is needed. The 1986 UCLA - Robert Wood Johnson Foundation national survey reports, for example, that those without health insurance were 33 percent more likely to be in "fair or poor health." Yet, the same survey found that despite evident greater need, the uninsured:

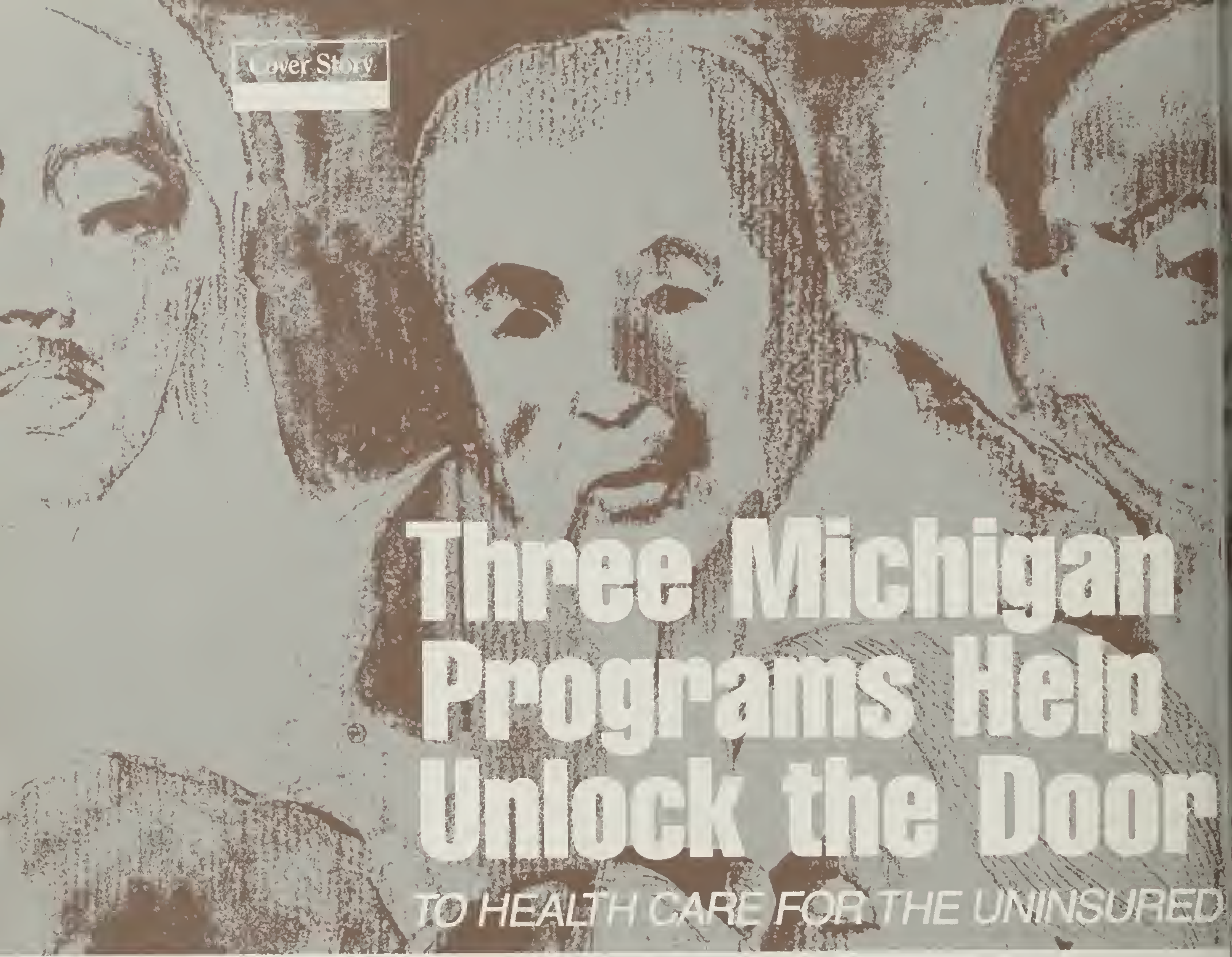
- *had 27 percent fewer doctor visits.*
- *had 19 percent fewer hospital admissions.*
- *were 33 percent less likely to begin prenatal care in the first trimester.*

One-fifth of the uninsured said they had not received needed care because of economic reasons.

Dramatically, persons without health insurance saw a physician 50 percent less often than the insured when they had symptoms of serious illness, such as unexplained bleeding, periodic loss of consciousness or chest pain when exercising.

As the above facts become more widely known, a growing consensus is developing that something needs to be done. A number of proposals have been advanced recently. There is no current consensus, however, on the precise path to follow to resolve the issue of the uninsured. ■

Cover Story



Three Michigan Programs Help Unlock the Door

TO HEALTH CARE FOR THE UNINSURED

By Chad B. Munger

Frostbitten feet, inadequate hygiene, chronic hypertension, pride — each is a symptom and a cause of the increasing unhealthiness of Michigan's uninsured population. Dignity and fear often stand in the way of those who must ask for care they cannot afford. Apathy, resentment and little hope of economic return sometimes prevent those who are capable of offering relief from doing so. As a result, relatively benign and treatable health problems fester among Michigan's uninsured citizens.

Michigan is a state where there are an estimated 27,000 homeless people. Unemployment, as well as homelessness, is a reality for many in Michigan, and many more struggle to survive on a job, or jobs, which offer low wages and no insurance.

Nearly all who find themselves homeless or underemployed also lack access to adequate health care. A vicious cycle, the homeless stay sick and the sick stay underemployed.

In at least three Michigan cities — Grand Rapids, Flint and Detroit — there is hope for better health care and a break in the succession of events that keep the homeless and underemployed down. In these cities three clinics with very similar goals are reaching out in different ways. For all three, the mission is the same: to provide access to quality health care for all who need it, regardless of their ability to pay.

The Heartside Clinic Grand Rapids

The Heartside Clinic, a storefront on Grand Rapid's Division Street, shares a wall with the Dwelling Inn, a shelter for the homeless, and is within sight of the Capitol Lunch, a local soup kitchen. By no means an elaborate facility, the Heartside is modestly staffed by a receptionist, a public health nurse, a social worker, and for a few hours a day, a physician.

The Heartside provides very few on-site medical services, instead referring most complicated medical problems to Saint Mary's or Butterworth hospitals, both of which provide the Clinic with medical and administrative support. Nevertheless, the Heartside provides something even more important for many of the Grand Rapids area's indigent and uninsured: a place to go where people really care. It may only be a shower, a pair of socks, or help getting X-rays from the hospital. Regardless of the service, the Clinic helps the homeless and uninsured to get something they could not or would not get on their own.

The Heartside attempts to "establish a friendly atmosphere," says Heartside Medical Director John Pierce. "It's a place where people feel comfortable coming in and asking to see someone."

Hamilton Family Health Center – Flint

Two hours to the east, in the center of northern Flint (a federally designated medically underserved indigent area), is the Hamilton Family Health Center. Michael Boucree, MD, MPH, directs the Center's medical staff which includes a full-time nurse practitioner, a general practitioner and an internist. The Center staff will soon expand to include a pediatrician, an additional general practitioner and a physician's aid.

Like the Heartside Clinic, the Hamilton Center is a storefront clinic which emphasizes the delivery of primary care. Unlike the Heartside, it provides a good deal of actual medical intervention on-site, including minor surgery, minor lab work, and dental surgery. The Hamilton Center also maintains a limited pharmacy. In addition to the services provided on-site, it has working arrangements with a number of local hospitals to which the staff makes referrals.

As in Grand Rapids, patients of the Hamilton Center often require the services of a social worker. A good deal of time is spent helping patients become Medicaid-enrolled or find available community services.

Non-medical assistance is a vital part of all three programs as it helps the homeless and uninsured feel more comfortable about seeking health care.

The Hamilton Center's approach to health care for the uninsured is service intensive. Through a project of the Center's, "Healthcare for the Homeless," Center staff provide basic non-emergency medical services. Each staff member works to promote the Center by going into community shelters and kitchens and informing the homeless and uninsured of the Center's services. During their visits to community shelters and the like, Center staff encourage the homeless and uninsured to pay more attention to their health.

"We feel it is vitally important for patients to feel that our staff is concerned about (the homeless and uninsured)," says Doctor Boucree. "All of our staff, from the secretaries to the executives, feel that same way — it doesn't make a difference what you have, just come in, that's what we're here for."

"Health Care on Wheels" Detroit

"Being there" for the uninsured and homeless is taking on an entirely new meaning in Michigan's Motor City. In Detroit, a joint project of the Wayne County Medical Society and the Detroit Medical Society will literally take health care to the streets — in a van. Dubbed "Health Care on Wheels," the Detroit program is scheduled to "hit the road" sometime this month.

The program will be staffed by up to 16 volunteer physicians and over 70 nonmedical volunteer staff recruited mainly from the church community. An equal number of specialty physicians have volunteered office hours to the program for referrals.

The program will rely on a fully-equipped medical van which will travel between nine churches around the city. Each church will provide space one or two days a week for physicians who, in turn, will deliver basic health care and information. The mobile van will provide not only storage and transportation, but also basic lab and examination facilities.

Richard Henderson, MD, initiator and director of "Health Care on Wheels" for Wayne County, sees this program as "an opportunity to get out and make up for the lack of health care available to indigents in the Detroit area."

Same health care problems

The health care problems faced by the homeless and uninsured are the same regardless of the location of the clinic or the approach to treatment that a clinic takes. One of the most persistent problems facing doctors who treat these people is simply getting the people who need help to feel comfortable about asking for it. So says both Doctors Boucree and Pierce.

The reluctance of many uninsured people to seek medical help they cannot afford is reflected in the types of problems most commonly seen in these clinics, according to Doctor Boucree. Patients visiting his clinic (roughly 90 percent of whom suffer from hypertension), have conditions referred to by Doctor Boucree as frequently "sub-acute" — a condition that has been left unattended for so long that is has become nearly chronic.

Doctor Pierce recognizes this problem also and says that, at his clinic, "People are often ignoring health care problems until they need to be hospitalized."

Healthier attitudes needed

Healthier attitudes about asking for and providing care to the homeless and uninsured will surely be one of the more pleasant side effects of all three programs. Changing attitudes is a slow and tenuous process though, and all three of these clinics rely heavily on public aid to continue operating.

Both the Heartside Clinic and the Hamilton Center receive Stewart B. McKinney Homeless Assistance Act grants, one of the few programs for the homeless supported by the Reagan Administration. At least in the case of Heartside Clinic, these grants are only matching funds and require the Clinic to come up with additional revenue on its own. These matching funds have come primarily from local churches and "in kind" support from local hospitals. The "Health Care on Wheels" program has been fortunate to find strong support in local medical societies and the Metro Health Foundation.

Support for programs strong

So far, all three programs have found strong support from local hospitals and pharmacies. Detroit's "Health Care on Wheels" program owes much credit to both the Wayne County and Detroit Medical societies for their continuing support of that project. Local religious organizations also have been important contributors to the success of these programs, especially in Detroit and Grand Rapids.

Like most other social programs, demand will soon outgrow the financial and logistical support these programs receive. It will require drastic changes in the grass roots structure of health care financing, changes brought about at the legislative level, before projects like those in Grand Rapids, Flint and Detroit are no longer needed.

Until financially significant employment is a reality for everyone, or health care coverage becomes universal, at least three Michigan programs will continue to lead the way to better health care for the homeless and uninsured. But, as Doctor Pierce points out: "It will continue to be a tragedy to need to do what we do." ■

Chad Munger is an East Lansing-based freelance writer.

Physicians are Invited to "RSVP" Research Support Program

MSMS President Fred W. Bryant, MD, (left) and Foundation President Robert W. Black, MD, announce a new Foundation program that offers physicians in private practice financial and technical support in developing clinical research proposals.

A program that offers physicians in private practice financial and technical support in developing clinical research proposals has been announced by the Michigan Health Care Education and Research Foundation. Titled the *Research Venture for Physicians* (acronym RSVP), the program intends to support private practitioners who would like to do research in ways to improve, change or make more efficient the practice of medicine.

The RSVP program is especially designed for the physician in private practice who has an interest in research but has lacked time, personnel, funds or expertise in developing various aspects of a research proposal, according to Ira Strumwasser, PhD, chief executive officer for the Foundation.

RSVP can put such physicians in contact with professionals who are experts in research project design and analysis, and can provide up to $5,000 to pay those experts to help develop the proposal.

There are no restrictions on the type of clinical care proposal a physician might wish to submit, but the Foundation currently emphasizes research in caring for the elderly.

Funding is limited to proposals from Michigan-licensed practicing physicians in private clinical practice. Physicians with academic appointments, and residents or interns, are invited to obtain information on the Foundation's professional program, *Research on Health Care for the Aged.*

Brochures, which explain in detail how to enter the RSVP program, are available from the Michigan Health Care Education and Research Foundation, 600 LaFayette East, B234, Detroit, MI 48226, or through the Foundation's consultation telephone (313) 225-7560.

The Michigan Health Care Education and Research Foundation is a philanthropic affiliate of Blue Cross and Blue Shield of Michigan. ■

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Michigan Health Care Education and Research Foundation* Extends an

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The Research Support Venture for Physicians is open to physicians whose primary focus is private clinical practice. The program offers financial and technical support to assist physicians in developing clinical research proposals. Any aspect of clinical care will be considered.

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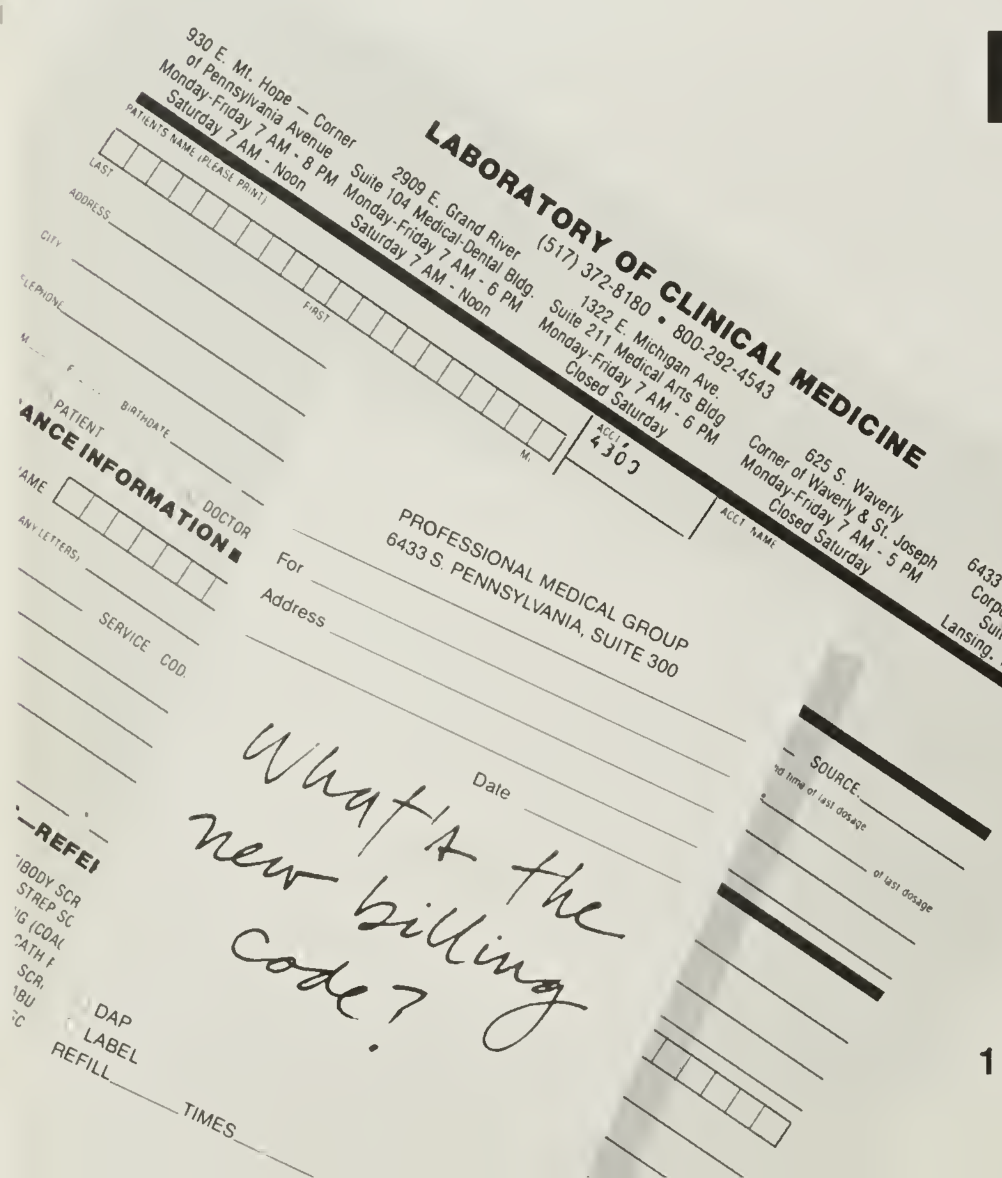
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Please see brief summary of prescribing information on next page.

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**BRIEF SUMMARY
CARDIZEM® SR
(diltiazem hydrochloride)
Sustained Release Capsules**

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), (4) patients who have demonstrated hypersensitivity to the drug, and (5) patients with acute myocardial infarction and pulmonary congestion documented by x-ray on admission.

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (nine of 2,111 patients or 0.43%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt) Experience with the use of CARDIZEM (diltiazem hydrochloride) in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using this combination.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** Mild elevations of transaminases with and without concomitant elevation in alkaline phosphatase and bilirubin have been observed in clinical studies. Such elevations were usually transient and frequently resolved even with continued diltiazem treatment. In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions tended to occur early after therapy initiation (1 to 8 weeks) and have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in some cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated, but available data are not sufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a 1-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Anesthetics: The depression of cardiac contractility, conductivity, and automaticity as well as the vascular dilation associated with anesthetics may be potentiated by calcium channel blockers. When used concomitantly, anesthetics and calcium blockers should be titrated carefully.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded from these studies.

The adverse events described below represent events observed in clinical studies of hypertensive patients receiving either CARDIZEM Tablets or CARDIZEM SR Capsules as well as experiences observed in studies of angina and during marketing. The most common events in hypertension studies are shown in a table with rates in placebo patients shown for comparison. Less common events are listed by body system, these include any adverse reactions seen in angina studies that were not observed in hypertension studies. In all hypertensive patients studied (over 900), the most common adverse events were edema (9%), headache (8%), dizziness (6%), asthenia (5%), sinus bradycardia (3%), flushing (3%), and 1° AV block (3%). Only edema and perhaps bradycardia and dizziness were dose related. The most common events observed in clinical studies (over 2,100 patients) of angina patients and hypertensive patients receiving CARDIZEM Tablets or CARDIZEM SR Capsules were (ie, greater than 1%) edema (5.4%), headache (4.5%), dizziness (3.4%), asthenia (2.8%), first-degree AV block (1.8%), flushing (1.7%), nausea (1.6%), bradycardia (1.5%), and rash (1.5%).

DOUBLE BLIND PLACEBO CONTROLLED HYPERTENSION TRIALS

Adverse	Diltiazem N=315 # pts (%)	Placebo N=211 # pts (%)
headache	38 (12%)	17 (8%)
AV block first degree	24 (7.6%)	4 (1.9%)
dizziness	22 (7%)	6 (2.8%)
edema	19 (6%)	2 (0.9%)
bradycardia	19 (6%)	3 (1.4%)
ECG abnormality	13 (4.1%)	3 (1.4%)
asthenia	10 (3.2%)	1 (0.5%)
constipation	5 (1.6%)	2 (0.9%)
dyspepsia	4 (1.3%)	1 (0.5%)
nausea	4 (1.3%)	2 (0.9%)
palpitations	4 (1.3%)	2 (0.9%)
polyuria	4 (1.3%)	2 (0.9%)
somnolence	4 (1.3%)	—
alk phos increase	3 (1%)	1 (0.5%)
hypotension	3 (1%)	1 (0.5%)
insomnia	3 (1%)	1 (0.5%)
rash	3 (1%)	1 (0.5%)
AV block second degree	2 (0.6%)	—

In addition, the following events were reported infrequently (less than 1%) or have been observed in angina trials. In many cases, the relation to drug is uncertain.

Cardiovascular:	Angina, arrhythmia, bundle branch block, tachycardia, ventricular extrasystoles, congestive heart failure, syncope.
Nervous System:	Amnesia, depression, gait abnormality, hallucinations, nervousness, paresthesia, personality change, tinnitus, tremor, abnormal dreams.
Gastrointestinal:	Anorexia, diarrhea, dysgeusia, mild elevations of SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase, thirst.
Dermatological:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, CPK increase, dyspnea, epistaxis, eye irritation, hyperglycemia, sexual difficulties, nasal congestion, nocturia, osteoarticular pain, impotence, dry mouth.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. Definitive cause and effect relationship between these events and CARDIZEM therapy cannot yet be established.

Issued 1/89

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MSMS
LEGAL COUNSEL Explains Physician Access to HCFA, MPRO Records

Editor's Note: *MSMS recently requested Thomas R. Williams, attorney, Kerr, Russell & Weber, Detroit, to explain the procedures physicians must follow to obtain information concerning themselves in records maintained by the Health Care Financing Administration (HCFA) and the Michigan Peer Review Organization (MPRO). The following is his response.*

Since HCFA administers the Medicare program and contracts with carriers to reimburse physicians under that program, it is not immediately obvious what information HCFA might possess of interest to physicians. I presume the main concern would be information gathered by MPRO and shared with HCFA, but I will discuss disclosure procedures concerning both of these entities.

HCFA is required by law to publish the names of physicians who have been found guilty of submitting false claims under Medicare, and HCFA may publish the names of physicians who have been found by a carrier to have consistently provided services in excess of beneficiary needs. This information may not be made public, however, until the physician has been afforded reasonable opportunity to offer evidence on his own behalf. This presupposes that the physician would have been provided with pertinent information in HCFA's files.

Access to HCFA records

Disclosure of information by HCFA and its employees is governed by Section 1106 (a) of the Social Security Act. Disclosure of any "file, record, report, or other paper, or information" obtained in administering the Social Security Act is prohibited "except as the Secretary may by regulations prescribe and except as otherwise provided by federal law." Regulations have been promulgated and are codified at 42 CFR 401.101 to 401.152.

The two statutes which impact upon the disclosure of information by HCFA are the Freedom of Information Act (FOIA), 5 USC S552 and the Privacy Act of 1974, 5 USC S552a.

In general, FOIA applies to every proposed disclosure of Medicare information. In general, information may be disclosed to any requestor or recipient of the information when the information would not be exempt from mandatory disclosure under FOIA or when the information, even if exempt from disclosure, nevertheless would be made available under the Department's public information regulations criteria for disclosures which are in the public interest and consistent with obligations of confidentiality and administrative necessity.

Any FOIA request for any record concerning a Michigan physician may be made to either of the following:

1.) Director, Office of Public Affairs, HCFA 313-H, Hubert H. Humphrey Building, 200 Independence Ave., Washington, DC 20201; or

2.) Director of Public Affairs, Department of Health and Human Services, Region V, 300 South Wacker Dr., Chicago, Ill. 60606.

The written request should reasonably identify the requested record by brief description. Any detailed information to assist in identifying the records should also be provided. The envelope should clearly be identified as a Freedom of Information request. The request should include a fee or request a determination of the fee.

In general, there is a charge of 10 cents per page for photocopying documents or records and a charge of $1.50 for each half-hour in excess of an initial half-hour for any time incurred in searching records. There are additional charges for preparation of materials from punch cards, magnetic tape or microfilm. Fees must be collected before requested materials are furnished.

Access to MPRO records

The Peer Review Improvement Act of 1982 has specifically exempted PRO's from FOIA. Although MPRO is under contract with HCFA, it is not itself a federal agency subject to FOIA. Thus, physicians may not access their MPRO files by this means.

Nonetheless, extensive regulations govern disclosure of information by PROs and are codified in 42 CFR S476.2, et. seq. Section 476.133 of the regulations covers disclosure of information about practitioners. A PRO *must* disclose to a particular practitioner information about himself, upon request, and *may* disclose it to him without a request.

In addition, a PRO must disclose to an institution, upon request, information about a practitioner to the extent the information displays practice or performance patterns of the practitioner in that institution.

With regard to a physician's ability to verify the accuracy of the information maintained by MPRO, under 42 CFR S476.134: (a) A PRO must verify the accuracy of its information concerning...practitioners...and must permit the individual...to request an amendment of pertinent information that is in the possession of the PRO.

Requests for information should be made with as much specificity as possible to: Michigan Peer Review Organization, 40500 Ann Arbor Rd., Plymouth, Michigan 48170.

MPRO will also assess charges for copying and search time. ■

MAY 1989

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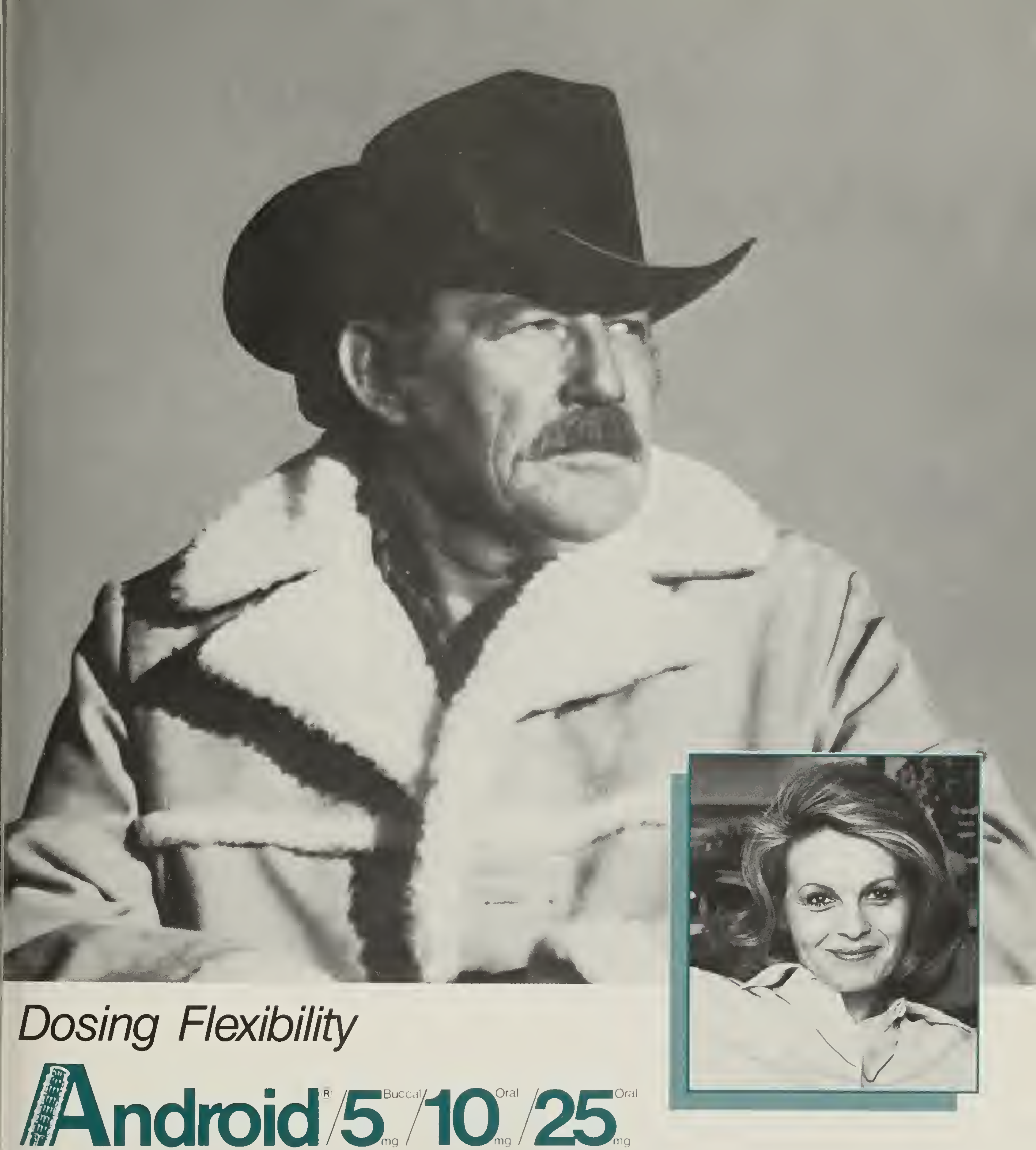

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By Elizabeth Yang

MSMS Offers Retirement Plan

Retirement Planning Important

Many financial planners suggest you begin saving for retirement as early as 20 years before you plan to stop working. That's because you must save a great deal if you want to enjoy a comfortable lifestyle in the years after you retire. Experts estimate you'll need 70 to 80 percent of your pre-retirement income to maintain the same lifestyle after retirement. Only by planning carefully now can you be sure you'll have enough to meet your future expenses.

The choices you have available for saving and investing for retirement continue to grow and change. You face a range of options, and you face an ever-increasing number of firms and managers eager to help you meet your financial goals for retirement. The idea is to choose the alternatives that offer the best future potential and the greatest advantage today. MSMS can help you ■

MSMS members can now take advantage of a new retirement plan being offered by the Society through an arrangement with The Equitable Life Assurance Society of the United States. A leader in the field of association retirement programs, Equitable Life is offering a quality, low-cost retirement program for MSMS members and their employees.

How it works

The program provides recordkeeping and administrative support, cutting the time and expense of setting up and maintaining a plan. Pension experts are available to support either you or your advisor.

Equitable will coordinate everything for you — the plan document, the annual administration, the actuary, the investment management and the record-keeping. Equitable will be happy to work directly with your accountant or attorney, if you prefer. You can call Equitable toll-free at 1-800-523-1125, Ext. 4409 and request a free proposal which will show you what you can expect from the types of retirement plans available to you.

Two types of plans

There are two different types of plans available to you: a *Defined Benefit Plan* and a *Defined Contribution Plan*. A Defined Benefit Plan is one in which the annual benefit at retirement is a predetermined amount. Actuaries will calculate the annual contributions you must make to receive the promised benefit at retirement. A Defined Benefit Plan may be right for you if you're in your late 40's or older, and if you're looking to shelter a large portion of your income from taxation, or build a retirement nest egg quickly.

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Elizabeth Yang is an account executive, Equitable Life Assurance Society.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

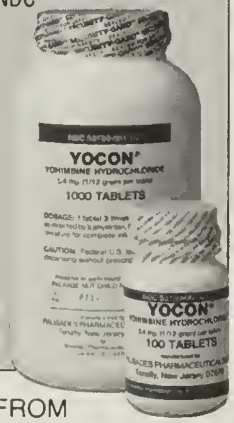
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Rep. David M. Gubow
Looking Toward the Future

By Chad B. Munger

"I try to look toward the next generation so that we are doing things that are not just politically popular today, but are genuinely the right thing to do — things that will help people not just today, but also in the future."

Politician — the stigmas associated with the word are inappropriate and soon forgotten in the presence of Representative David M. Gubow, who displays a disarming sense of humor and obvious concern for the individuals he serves. In the words of this Huntington Woods Democrat: "Politicians tend to always look toward the next election, and everything they do tends to be politically motivated. I don't try to act that way at all. I try to look toward the next generation so that we are doing things that are not just politically popular today, but are genuinely the right thing to do — things that will help people not just today, but also in the future."

Representative Gubow is a member of the House judiciary, mental health and public health committees, and is chairman of an ad-hoc committee on physician licensure and discipline. To these duties he brings a strong background in law — he is a graduate of the University of Detroit School of Law, is a practicing attorney and has a broad base of practical experience.

The "active concern" he has for many public and mental health issues is a result of his practical experience with nursing homes and state mental health facilities.

As an college undergraduate, Rep. Gubow was a member of "Citizens for Better Care," a group interested in improving conditions found in Michigan nursing homes.

Early experiences as a lawyer have given him a perspective on Michigan's mental health situation. "As a young lawyer, I had a good deal of experience with commitment procedure to state hospitals," he said. "I had a number of opportunities to see the conditions there."

Health care legislation

Involvement in both the mental and public health committees has required Rep. Gubow to be a key figure in some of Michigan's most controversial and emotionally charged health care legislation. In the last session he introduced legislation relating to mandatory assignment and the state medical liability trust fund — legislation Rep. Gubow feels "may have been misunderstood."

The state medical liability trust fund, which Rep. Gubow re-introduced this session, was intended to be used solely as a tool for addressing any liability or malpractice issues which might surface. "At this point there is no intent on my part to take that bill up or have it acted upon," he says. "It is just there as a vehicle."

The medical liability issue has a whole dimension regarding insurance that has not yet been addressed, says Rep. Gubow. "A study released from Minnesota showed that insurance companies were ripping off doctors, making unconscionable profits at the expense of doctors by charging really high premiums. I don't know what the situation is in Michigan, but we have to examine the insurance aspect and perhaps make some reforms."

Reducing premiums is not, however, the only obstacle to reducing Michigan's liability woes, says Rep. Gubow. "Even with low rates, physicians have an underlying desire not to be sued. I think that it is time to re-examine the entire system instead of just continuing to make changes in torts." This summer, Rep. Gubow, along with a group of members from MSMS and other professional organizations, plan to travel to Sweden to examine that country's no-fault system.

As for mandatory assignment, Rep. Gubow says it is "every bit as controversial as medical malpractice in Michigan." Although he has not yet re-introduced his mandatory assignment legislation, he does not rule out the possibility. This issue "has not been a major problem in Michigan *yet*," he says. "I introduced the legislation last session so the issue could be brought to the table for discussion."

Mandatory assignment legislation introduced by Rep. Gubow may have been misinterpreted, says the representative. "My bill simply said that if you did choose to accept Medicare payment, that was all you could accept. You would still be free as a physician to not take Medicare patients and charge whatever you want." Rep. Gubow's proposed legislation differs from that in other states in that is is not tied directly to licensure.

Future plans

Medical malpractice and mandatory assignment are issues that tend to steal headlines when being discussed, and they are important issues Rep. Gubow will continue to play a role in helping to resolve. His real interest, however, lies with issues lesser known, but more directly relevant, to many people in and out of the health care profession.

A "statesman" from the 67th district, Rep. Gubow is committed to finding balance, whether it's between the House and Senate or today's political wants and tomorrow's social needs. ■

Chad Munger is an East Lansing-based freelance writer.

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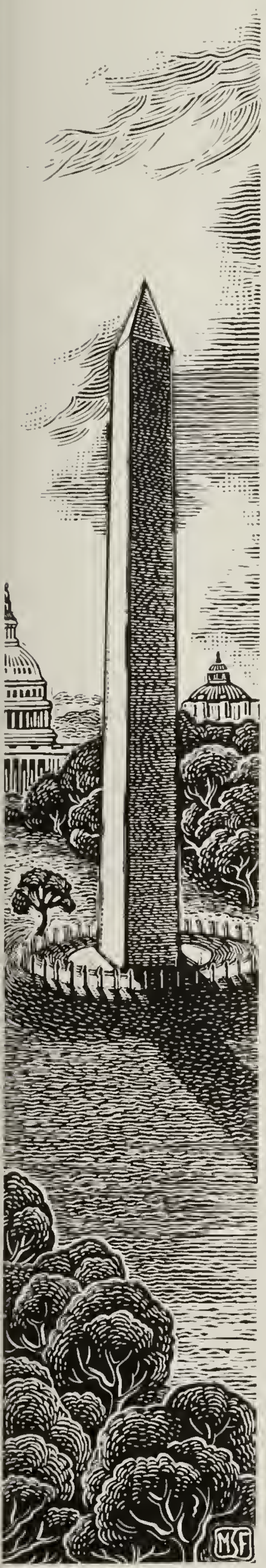

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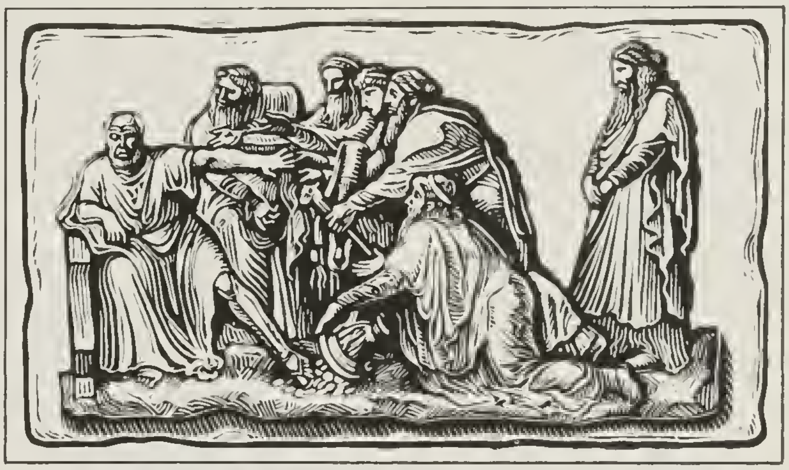

Because the commemorative stone has suffered from severe erosion and defacement, the American Medical Association is launching a campaign to raise money from physicians to restore this symbol of medicine for the National Park Service. Every contribution made to this effort will serve as a statement of each physician's personal affirmation and commitment to health and medicine in America.

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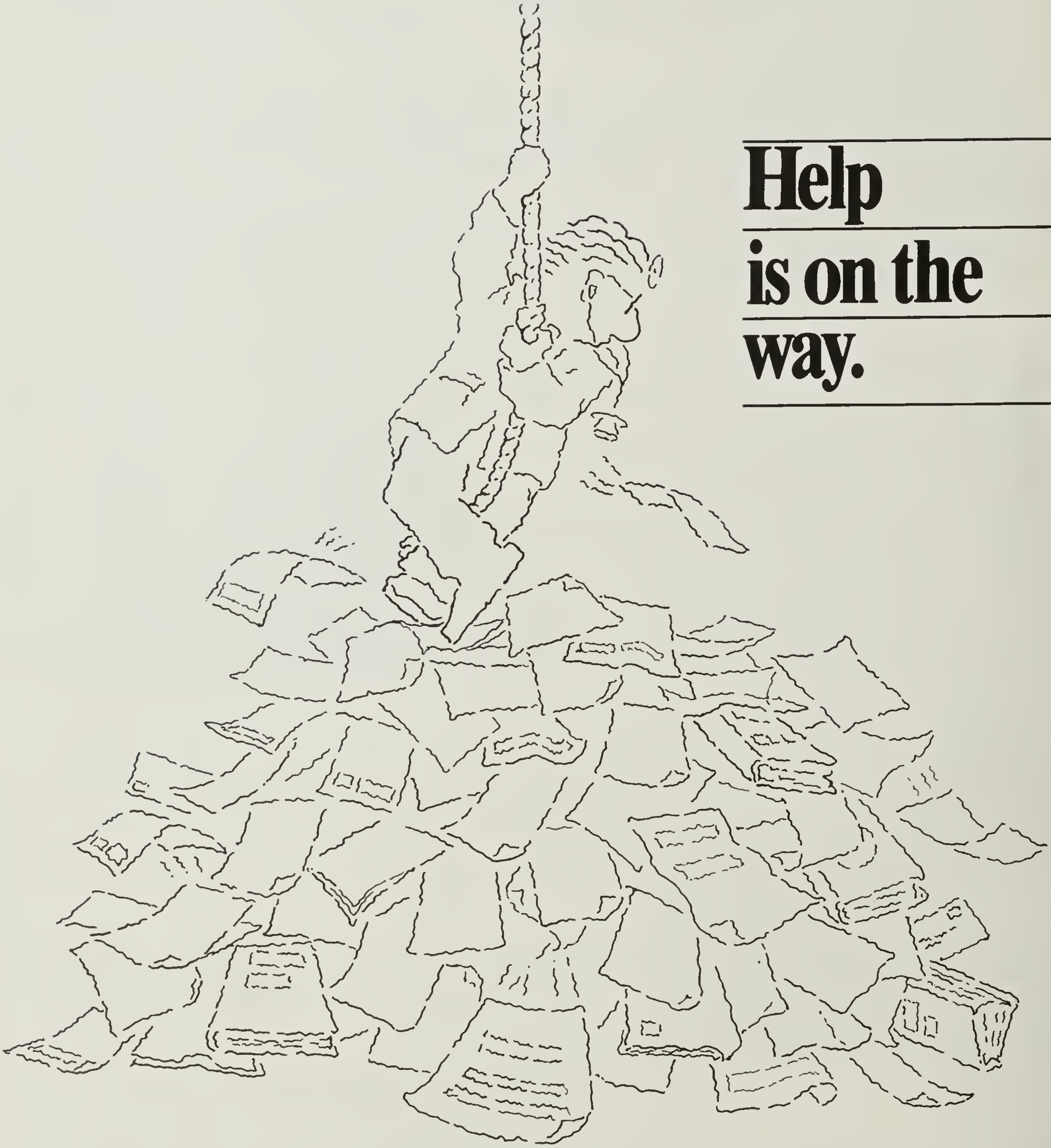

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MSMS YOUNG PHYSICIANS SECTION

MEETING HIGHLIGHTS

Approximately 45 delegates attended the first meeting of the MSMS Young Physicians Section March 2 in Lansing. Representing 36 counties, they discussed 17 resolutions which resulted in 15 resolutions to be brought to the MSMS House. Some of the issues discussed were: the impact of claims made insurance on young physicians; BCBSM audit procedures; third party cost containment programs; health services for teens; long-term care insurance; physician licensing requirements; and drunk driving in Michigan. Also during the meeting, five persons were elected to serve on the Section's first Governing Council. The new officers are: Richard A. Stone, MD, chairman; Thomas J. Archambeau, MD, vice chairman; Tama D. Martini, MD, secretary; Dean Gerald Sienko, MD, delegate to MSMS; and Thomas M. George, MD, alternate delegate to MSMS.

Richard A. Stone, MD, delegate for Macomb County, is chairman of the MSMS-YPS Section.

In addition to debating 17 resolutions, MSMS/YPS delegates and alternate delegates had the opportunity to hear a variety of speakers during the day-long meeting. Pictured above are Steven Sherman, MD, Livingston County delegate (left) and Rahul Saugal, MD, Oakland County alternate delegate (right).

Mark D. Kolins, MD, of Wayne County, served as chairman of Reference Committee B. He is an At-Large member of the MSMS-YPS Governing Council.

OS
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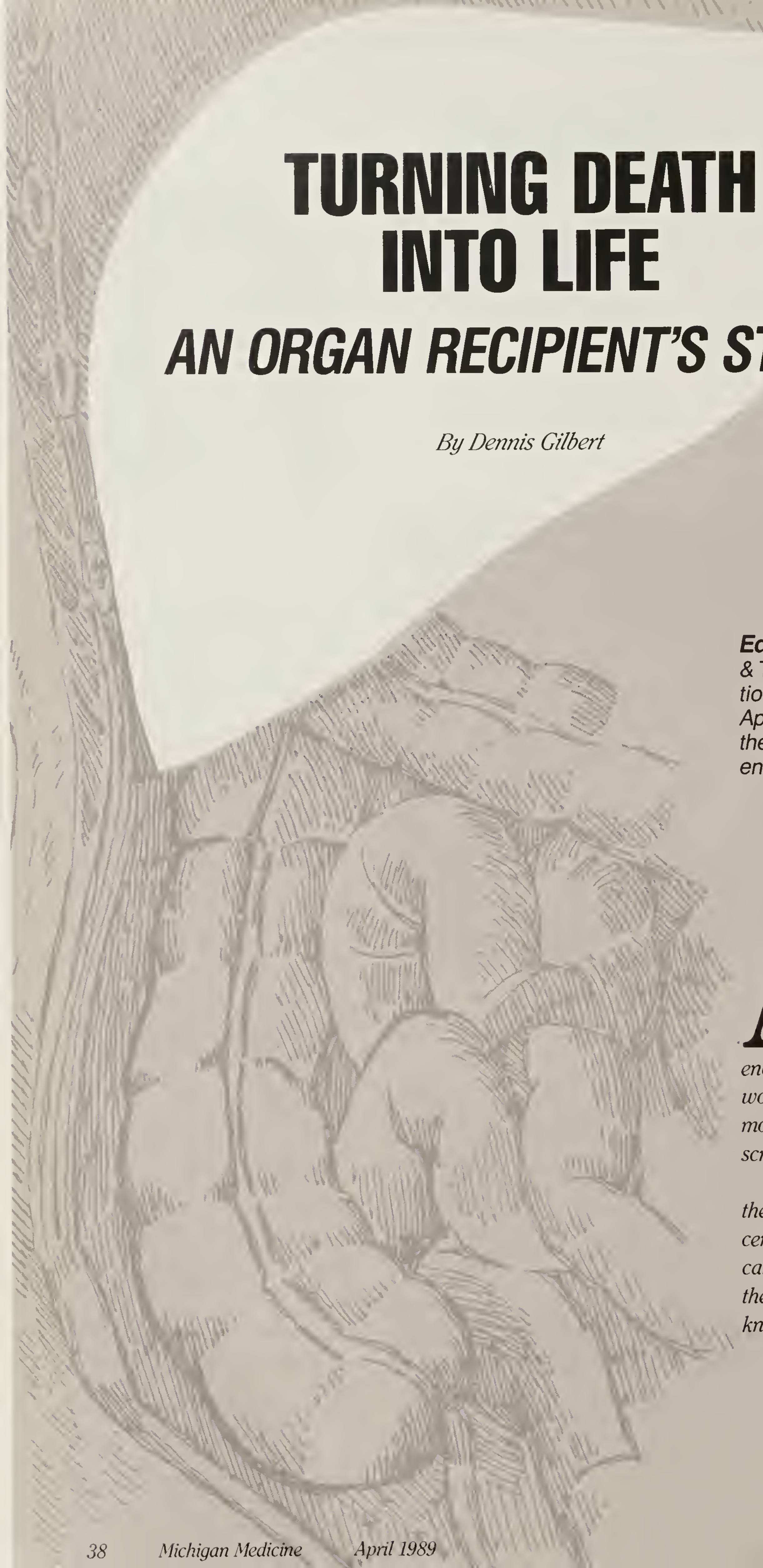
Two reference committees were responsible for reviewing resolutions, hearing testimony and making recommendations on resolutions at the MSMS-YPS Meeting. Pictured above are members of Reference Committee A. They are (l to r): Gary G. Doss, MD, delegate, St. Clair County; Mark J. Heinzelmann, MD, delegate, Saginaw County; Patricia S. Melzer, MD, delegate, Alpena County; and Domenic R. Federico, MD, committee chairman.

Edward Hirshfield, JD, AMA associate general counsel, was one of the featured speakers at the meeting. He identified four "pertinent" legal issues affecting medical practice: professional liability, Medicare's "medically unnecessary" claims process; antitrust and price fixing; and physician referrals.



TURNING DEATH INTO LIFE

AN ORGAN RECIPIENT'S STORY

By Dennis Gilbert

Editor's note: *In recognition of "Organ & Tissue Donor Awareness Week," a national and state promotion slated for April 23-29, Michigan Medicine presents the following story of one man's experience as an organ recipient.*

After 20 years as a newspaper reporter, Bill Cote, assistant professor of journalism, Michigan State University, has written words enough to fill volumes. But none of the words he's written or read have ever had more meaning than a certain few, hastily scrawled on a small piece of paper.

"A week or so after my liver transplant, the hospital had gathered together its recent kidney and liver recipients for an education class," Cody recalls. "After a while, the instructor asked us if we would like to know something about our organ donor.

"We all paused a moment, and then most of us said, 'Yes, we would.' The hospital had prepared some handwritten notes for each of us...and it was one of the hardest things I've ever read. It had my name on it, and then, after it, 'Marquette General Hospital, Marquette, Michigan, 15-year-old girl."

His voice breaking with emotion, Cote pauses a moment to compose himself, then continues. "The impact is indescribable...knowing that through a final act of generosity, someone has literally given you the gift of life. You can't help but feel a special kinship with your donor, even though you never knew that person in life.

"I hold onto that knowledge, and hope that the family's loss of that 15-year-old girl was in someway softened by knowing that part of her still lives on. Her generosity gives special meaning to both my life, and hers."

The long road downhill

Cote, 48, received his new liver July 10, 1988, after nearly two decades of intermittent hospitalization. Originally diagnosed as having lupoid hepatitis, his illness was later classified as chronic active hepatitis; difficult to live with, but often medically manageable. Then, in 1980, Cote had several life-threatening internal bleeding episodes. Each time, only fast action in a hospital emergency room kept him alive.

"As my condition worsened, I had less and less energy to do my work, much less to have any meaningful social life," he says. "My job was tough as far as hours were concerned. Only by husbanding all my strength was I able to do my job minimally."

Eventually, even that became too much for him.

In the spring of 1988, Cote went down again, this time while visiting New Orleans. He was rushed to Tulane Medical Center where physicians suggested he begin looking seriously, and soon, at a liver transplant.

"The doctors at Tulane told me it was a terminal condition," Cote explains. "I went to the University of Wisconsin Hospital, Madison, and University of Michigan Hospitals for second and third opinions, but the news was the same. I was informed that I had a few months to live, maybe several months."

With no medical recourse left, Cote met with a specialist in liver transplant surgery at University of Wisconsin Hospitals where they decided to put Cote's name on the list of people waiting for donations of transplantable organs.

"I was told, then, that it would take anywhere from one to three months to locate a liver that matched my blood type and liver size," Cote notes. "Still, I considered myself lucky. Blood typing isn't as critical with livers as it is for kidneys or ears. The waiting list for those organs is many times longer."

Twenty-eight days later, the call came from the UWH surgeon who would be performing the transplant: "Mr. Cote, how soon can you get to Madison? We have a liver for you."

A second chance at life

Since the surgery, Cote has been back at UWH just once; for a routine, three-month check-up. He also sees his local physician every six weeks, has weekly diagnostic blood tests, monitors his blood pressure on a daily basis (one side-effect of his antirejection medication is that he now has high blood pressure), and relies on a carefully programmed regimen of diet and weight control to keep his body chemistry in balance. Like all transplant patients, he will always have to monitor his health meticulously, and his survival will always be linked to medication — particularly antirejection drugs.

Thanks to a great many clinical and research advances over the last 20 years, a liver transplant recipient today has a better than 80 percent chance of living five years or more. "Because all transplant programs are so few, there just isn't enough history to accurately project results any further than five years," Cote says.

All things considered, however, Cote has resumed a relatively normal life. "Most people wouldn't consider it normal, but it's more normal than I've had for quite a while," he says. Now working two-thirds time as an assistant professor at Michigan State University, Cote expects to work himself gradually up to full-time as his strength returns.

While he admits that he misses being the state capitol correspondent for Booth newspapers — a post he held for 15 years — Cote says he "very much enjoys teaching. It's very stimulating, working with bright young people. I live journalistically through them now; helping them start off their own careers, imparting what wisdom I can."

Yet the most profound effect transplant surgery has had on Cote's life is the new appreciation he has found for life's most common pleasures. "Looking at the night sky or feeling sunshine on my face, listening to music, enjoying the company of friends — all the little things in life we tend to take for granted have special meaning to me," Cote says. "Things don't bother me as much as they used to. When you come face-to-face with your own mortality, when you truly come to see the wonderful gift life is, you perceive it with new clarity."

A long-time believer in the cause of organ and tissue donation, Cote had designated his own for donation before he knew he would someday be on the receiving end.

"Pledging your organs and tissues doesn't cost you a thing in time, money or effort," he says. "It is absolutely painless to the donor; but it can mean the difference between life and death for a half-dozen or more other people. I can't think of a gift that has greater value than the gift of life. Can you?"

Breaking the silence

To stimulate more open and candid discussion of an organ and tissue donation shortage among family members, the Michigan State Medical Society, the State Bar of Michigan, and the Michigan Hospital Association have jointly launched a public information campaign called "Break the Silence." The campaign includes radio and television spots and widescale distribution of a brochure outlining the donation process.

By marshalling the 27,000-member State Bar, the 11,000-member MSMS and the 194-member hospitals of the MHA, campaign organizers hope to carry the message to every community in the state.

Further information on the "Break the Silence" campaign may be obtained by contacting David K. Fox, MSMS chief of media relations, at (517) 337-1351. ■

The author is a Dexter-based freelance writer.

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IN THE NEWS

Right: *Sen. John J.H. Schwarz, MD, left, testifies to members of the Senate Health Policy Committee about his bill to regulate the use of all terrain vehicles. The bill outlaws the use of ATVs by children under 13 and requires parental supervision by those 13 to 16. Helmet use and eye protection would be mandatory. Six televison crews and several newspaper and radio stations covered the mid-March committee hearing during which the father of an ATV victim testified.*

Left: *Sen. William Sederburg, left, and Elliot Grysen, MD, JD, right, look over the ATV bill with sponsor Sen. John J.H. Schwarz, MD. Physician support of the ATV bill helped it sail out of committee on a unanimous vote. It then passed the Senate on a vote of 31-7. Now the bill faces stiff opposition from the motorcycle lobby in the House. The Detroit Free Press and The Grand Rapids Press have endorsed this MSMS-supported legislation.*

Top: *MSMS President Fred W. Bryant, MD, makes a point during his testimony to the ad hoc committee on physician licensure and discipline chaired by Rep. David Gubow of Huntington Woods. The committee is expected to complete hearings by early summer.*

Left: *Rhoda Powsner, MD, of Ann Arbor, chairman of the MSMS Committee on Medical Licensure and Discipline, testifies before a special House committee which is looking at how the Board of Medicine currently functions and at the possibility of physicians licensing and discipling themselves with a system similar to that used by the State Bar. Accompanying Doctor Powsner is MSMS legal counsel Richard Weber.*

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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
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Reference:
1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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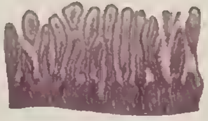
Aspirin and other nonsteroidal anti-inflammatory drugs weaken mucosal defenses, which may lead NSAID users to become prone to duodenal ulcers[1] For those NSAID users who do develop duodenal ulcers, CARAFATE® (sucralfate/Marion) is ideal first-line therapy. Carafate rebuilds mucosal  defenses through a unique, nonsystemic mode of action. Carafate enhances the body's natural healing ability while it protects damaged mucosa from further injury. So the next time you see an arthritis patient with a duodenal ulcer, prescribe nonsystemic Carafate: therapy for the ulcer-prone patient.

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Please see brief summary of prescribing information, and reference on adjacent page.

0160N8

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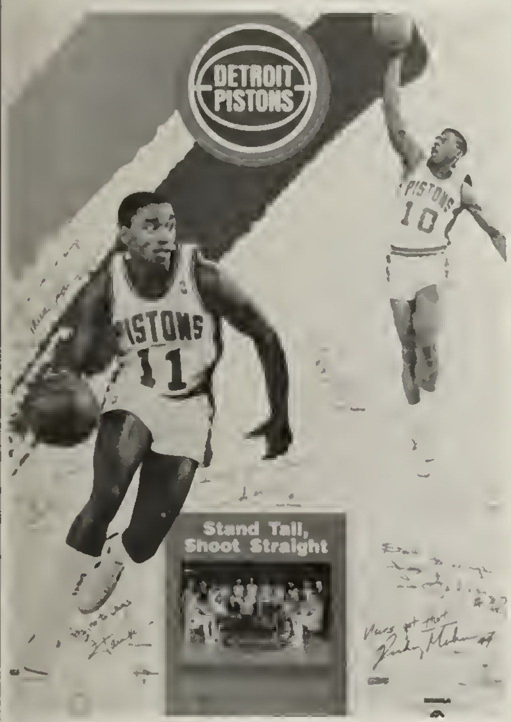
MSMSA Campaign Targets Youth Substance Abuse



This poster, which features a photo of Isiah Thomas, is part of the MSMSA campaign now underway to help combat youth substance abuse. Posters have been mailed to every school in the state.

A coalition of state health and education organizations has joined forces to combat alcohol and drug use by school children throughout Michigan by providing positive role models — Isiah Thomas and the Detroit Pistons.

Led by the Michigan State Medical Society Auxiliary (MSMSA), the coalition's goal is to help young people say "No" to alcohol and drugs.

The campaign, now underway, includes a colorful poster featuring a photograph of Isiah Thomas and his personal anti-drug message, "Don't foul out." The poster includes messages from players such as Adrian Dantley who says "Get high on life, not drugs," and Bill Laimbeer who says "Say no to drugs." Under the poster's headline, "Stand Tall, Shoot Straight," is a Detroit Piston's team photo.

A second part of the campaign is a video starring Isiah Thomas entitled, "No Matter How You Say It, Say No to Drugs."

Posters have been mailed to every school in the state along with information about obtaining a copy of the video. A second printing of posters has just been completed to increase distribution to every student who wants one for display in his or her own room.

"Our children need every resource we can provide to help them say 'no' to drugs," says MSMS Auxiliary Project Coordinator Marianne Wiedemer of East Lansing. "We hope these posters will be a constant reminder that winners don't need drugs. For my children, and I'm sure for many others, if Isiah says that's true, it's true."

The coalition includes the Michigan State Medical Society and Auxiliary; the Michigan Education Association; the Michigan Hospital Association; the National Council on Alcoholism Michigan, Inc.; the Health Education Foundation; The Upjohn Co.; the Michigan Office of Substance Abuse Services; the Michigan Department of Health Education; General Motors; the Michigan Association of Osteopathic Physicians and Surgeons; and the Michigan Parent Teacher Association.

The effort will continue throughout the rest of the year. For campaign information, contact Marianne Wiedemer, MSMSA project coordinator, at (517) 337-1473. ■

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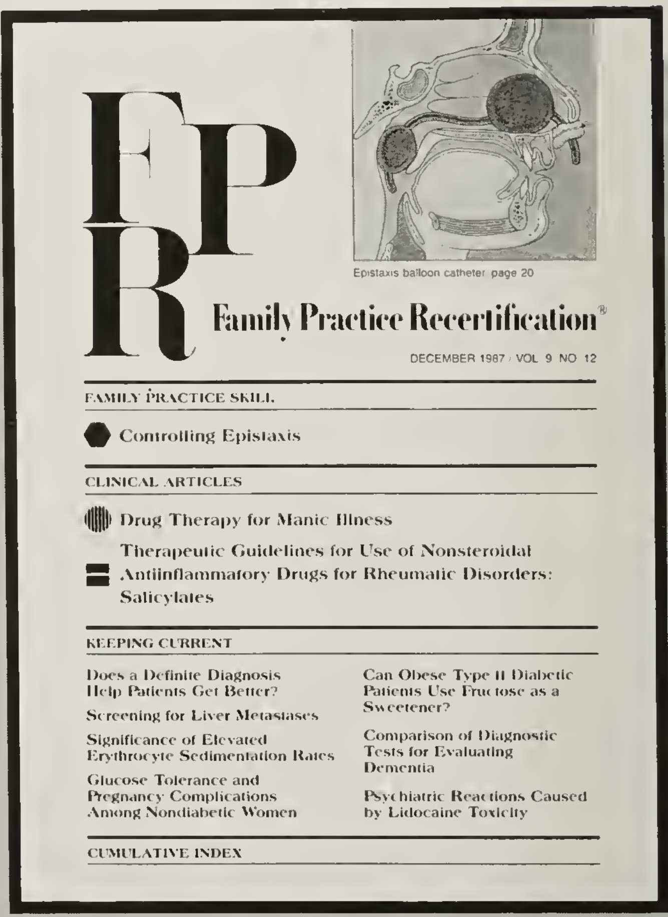

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Epistaxis balloon catheter page 20

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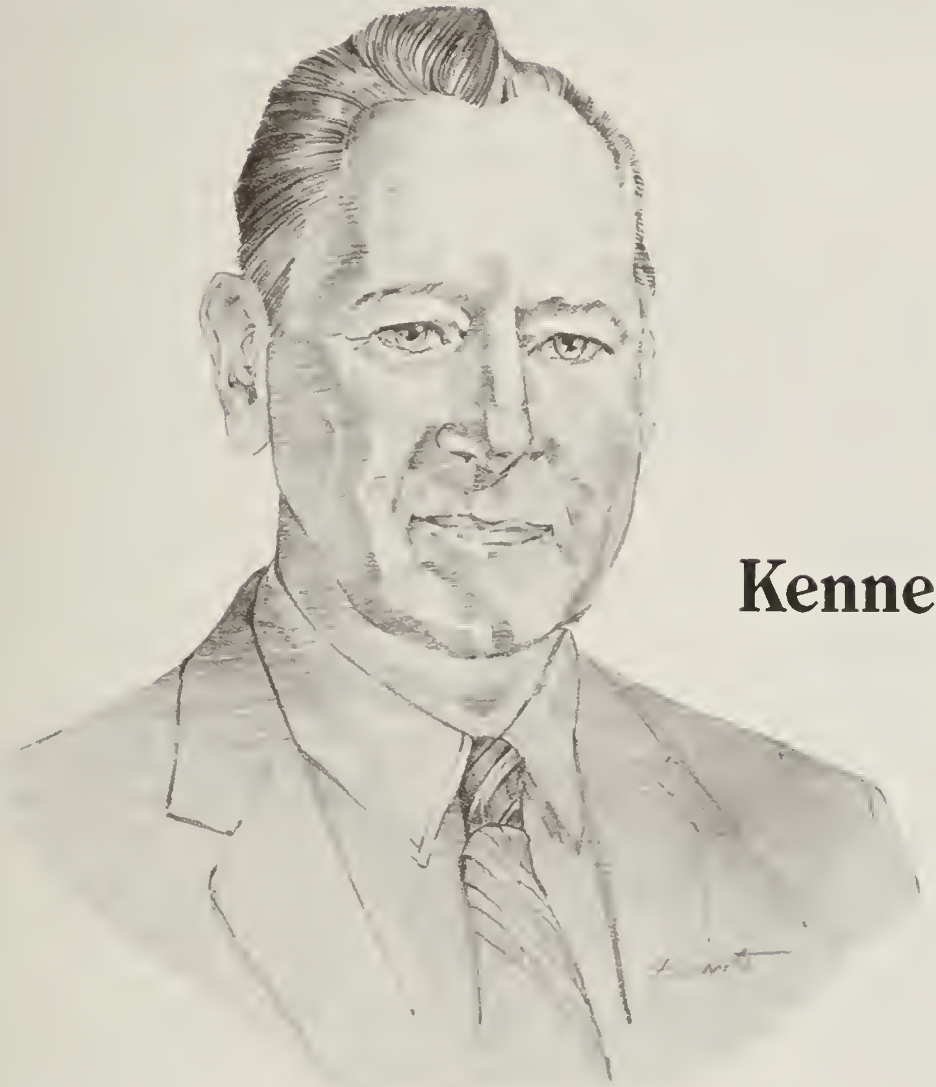

Kenneth H. Johnson, MD

By Warren F. Tryloff

Long-time MSMS leader Kenneth H. Johnson, MD, who died February 25, lived a wonderful 80 years. His was a rewarding life, one of healing and of befriending mankind. If only all of us could achieve our life goals and ambitions as he did!

Doctor Johnson was first a physician — everything else was secondary to him.

His patients idolized him. He cared for them as friends, and ministered to their spirits and souls, as well as to their bodies. I suppose he spent as much time just listening as he did in prescribing and diagnosing.

I've often thought he may have been afflicted with an excess of empathy, and I suspect his hospital rounds took longer than anyone else's, for he had to stop and see each friend for a little chat and a word of encouragement.

Doctor Johnson loved medicine — the actual practice of it, and the nourishment of it as a profession.

He began practicing in Lansing in the mid-1930's, after premedical studies at Michigan State University, medical school at the University of Michigan, and residency at E.W. Sparrow Hospital. He ended his practice in Lansing 50 years later.

In 1940-45, Doctor Johnson served with the Army Medical Corps, returned to practice in Lansing and began a life-long commitment to organized medicine. He served first as Ingham County Medical Society secretary and then as the county society's president for two years.

Next Doctor Johnson began a sequence of services to the state medical society. In 1954 he was named vice speaker of the MSMS House of Delegates. This was followed by several years as speaker (1956-1959). He culminated this period by serving as MSMS president-elect and then as president in 1960-1961.

Normally, old presidents just fade away after they have served in an organization's highest office. Not Doctor Johnson. MSMS would not let him go. He served as MSMS secretary from 1967-1975.

Of all his contributions to organized medicine, however, Doctor Johnson was proudest of his role in planning the headquarter's move from 606 Townsend St., Lansing, to East Lansing.

The current headquarters became "his" building. He helped select the site, choose the architect, Minoru Yamasaki, develop the plans and oversee construction. It was right for him to be the central figure at the dedication in 1961 — the year of his presidency.

Doctor Johnson continued as building advisor for many years — overseeing the maintenance and integrity of the building's exterior and interior design. He was very protective. "Woe unto him" who placed a briefcase on the 45-foot-long walnut table in the boardroom.

Doctor Johnson's love for and dedication to the headquarters was recognized in 1981 with the naming of the conference room in his honor.

A couple years ago he gave up his practice in the Olds Tower in downtown Lansing so he and his wife, Vivian, could begin to "take it easy."

He took it easy to remember the good things, the good times and the good friends.

I know he was proud of his life and his service to his community and humanity. And we are proud of him — proud to have known him as a physician, friend, father and husband. ■

Warren Tryloff served as MSMS executive director from 1970 to 1984.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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6450 Farmington #101
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Inkster, 48141

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Hancock, 49930

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Bloomfield Hills, 48013

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Kalamazoo, 49007

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Detroit, 48201

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Ypsilanti, 48197

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Southfield, 48034

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Grosse Pte., 48230

Continued on page 50

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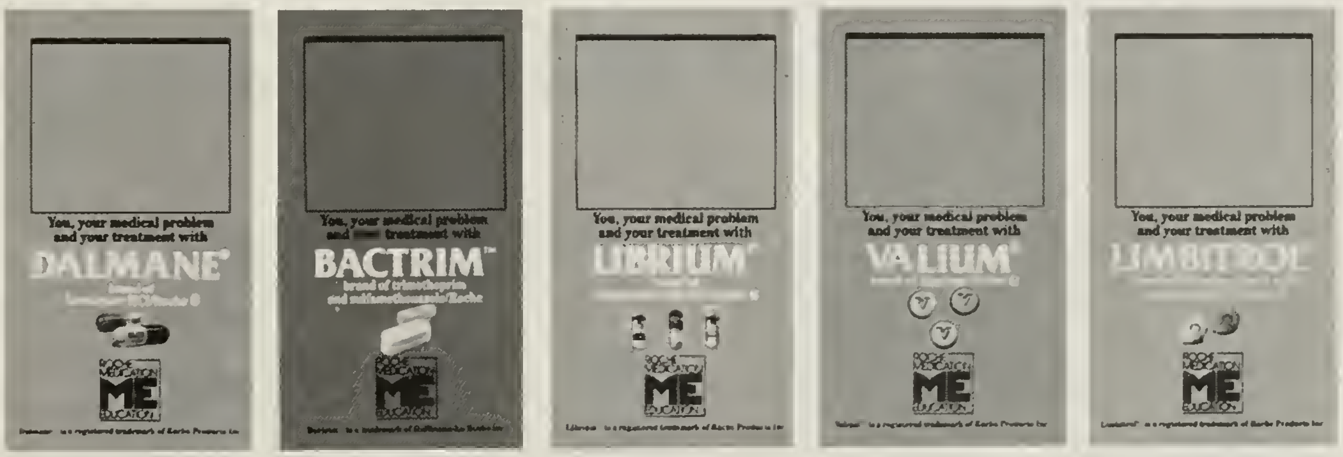
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CATEGORY I COURSES

April

26, Current Women's Health Care Issues. Location: Genevieve U. and Donald S. Gilmore, Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road, Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. **Approved for:** 6 hours Category I Credit.

26-28, Advances in Computed Tomography and Magnetic Resonance Imaging. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 22 hours Category I Credit.

29, Sleep Disorders in Clinical Practice. Location: Management Education Center, Michigan State University, 811 Square Lake Road, Troy, Michigan. **Sponsor:** Sleep Disorders Institute. **Contact:** R. B. Sangal, MD, Director Sleep Disorders Institute, 44199 Dequindre #403, Troy, MI 48098 (313) 879-0707. **Approved for:** 5 hours Category I Credit.

May

5-6, Pediatric Advanced Life Support. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 18 hours Category I Credit.

11, MSMS Conference on Sports Medicine. Location: Hilton Inn, Lansing, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, Chief of Physician Education, Michigan State Medical Society, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351. **Approved for:** 6 hours Category I Credit.

11-12, The Restenosis Summit, An International Symposium with Live Demonstrations. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14.5 hours Category I Credit.

12, 11th Annual ACP-Michigan Chapter Associates Meeting. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** American College of Physicians, Michigan Chapter. **Contact:** Jan Rival, MD, FACP, Henry Ford Hospital, Department of Internal Medicine, 2799 Grand Boulevard, Detroit, MI 48202 (313) 876-1895 or 876-2059. **Approved for:** 6 hours Category I Credit.

14, Identification and Diagnosis of Mental Illness in the Developmentally Disabled. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Department of Continuing Medical Education, Southwestern Michigan Area Health Education Center, 1535 Gull Road-Suite 230 M.S.B., Kalamazoo, MI 49001 (616) 383-7363. **Approved for:** 5.5 hours Category I Credit.

15-19, 17th Annual Spring Update: Advances in Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 34 hours Category I Credit.

19-20, Recent Advances in Cornea, External Disease, and Cataract: 61st Annual Ophthalmology Spring Conference. Location: W.K. Kellogg Eye Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

31-6/2, Current Topics in Blood Banking: 16th Annual Symposium and Workshops. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

June

1-2, Fifteenth Annual Symposium for Michigan Neonatologists and Neonatal Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Neonatology Service, Bronson Methodist Hospital, (616) 341-6469. **Approved for:** 7.25 hours Category I Credit.

2, Ultrasonic Liver Surgery. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School Parenteral and Enteral Nutrition Team and Department of Surgery. **Contact:** Betty Phillips, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, U-M Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 8 hours Category I Credit.

5-6, Third Annual Cardiology Symposium for Nursing. Location: Ford Auditorium, University of Michigan Hospital, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

7-9, The 7th Annual Clinical Laboratory Computer Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 15 hours Category I Credit.

19-23, 25th Annual Northern Michigan Summer Conference. Location: Shanty Creek - Schuss Mountain, Bellaire, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

July

20-21, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Re-

Continued on page 54

CATEGORY I COURSES

Continued from page 53

sort, Traverse City, Michigan. **Sponsor:** Munson Medical Center, Traverse City. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386 (616) 922-9546. **Approved for:** 9-13 hours Category I Credit.

23-26, 3rd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

August

6-9, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

18-21, Cardiology Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

25-28, 15th Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

25-27, Endocrinology and Diabetes Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category I Credit.

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MEETINGS

MSMS Meetings

May

5-7, MSMS Board of Directors and House of Delegates, Hyatt Regency Dearborn, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

8-10, MSMS Auxiliary Annual Session, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, MSMS/Physician Service Group, Account Executive, (517) 337-1351.

11, MSMS Conference on Sports Medicine, Hilton Inn, Lansing, Contact: Sherry L. Fent, MSMS Chief of Physician Education, (517) 337-1351.

AMA Meetings

April

24-25, AMA "Unlocking Potential: The Promise of the Human Genome Initiative" J.W. Marriott Hotel, Washington, DC. Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-4417.

May

10-12, AMA First International Congress on Peer Review in Biomedical Publication, Congress Hotel, Chicago, Illinois, Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-4417.

June

18-22, AMA House of Delegates Annual Meeting, Chicago Hilton, Chicago, Illinois, Contact: AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-5000.

Michigan Specialty Society Meetings

April

26, Michigan Society of General Surgeons, Board Meeting, Canopy, Brighton, Contact: Caroline Kimmel, P. O. Box 950, East Lansing, MI 48826 (517) 337-1351.

28, Michigan Thoracic Society/American College of Chest Physicians, Michigan Chapter, Annual Scientific Sessions, Sheraton Oaks Hotel, Novi, Contact: Robert E. Klimek, MD, 337 Chesterfield Parkway, East Lansing, MI 48823 (517) 334-2345.

28-30, Michigan Society of Medical Assistants, 39th House of Delegates, Sheraton Inn, Lansing, Contact: Caroline Kimmel, P. O. Box 950, East Lansing, MI 48826 (517) 337-1351.

29, Michigan Society of Anesthesiologists, 34th Annual Scientific Session, Novi Hilton, Novi, Contact: Caroline Kimmel, P. O. Box 950, East Lansing, MI 48826 (517) 337-1351.

May

4-5, Michigan Chapter, American College of Surgeons, "Coller Day Competition and Scientific Session" Sheraton University Inn, Ann Arbor, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

11, Michigan Psychoanalytic Society, "The Invisible Loss: Dynamics and Treatment of Perinatal Sibling Death," Southfield, Michigan, Contact: Shirley Seffinger or Colleen Jaeger, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076 (313) 557-8633 or (313) 559-5855.

June

1-2, Michigan Occupational Medical Association Spring Scientific Seminar, Bay Valley Hotel and Resort, Bay City, Contact: John Bernick, MD, 20900 West Road, Woodhaven, MI 48183 (313) 671-7251.

3, Michigan Society of Pathologists Spring Meeting, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

22-24, Michigan Orthopaedic Society Annual Meeting, Boyne Highlands, Contact: Arthur Manoli, II, MD, Orthopaedic Surgery, Hutzel Hospital, 4707 St. Antoine, Detroit, MI 48201 (313) 745-6955.

22-25, Michigan Otolaryngologic Society, Annual Statewide Meeting, Contact: Karen Turner, Wayne County Medical Society, 1010 Antietam Road, Detroit, MI 48207 (313) 567-1640.

July

10-12, Sixteenth Michigan Emergency Medicine Assembly/Annual Meeting, Grand Hotel, Mackinac Island, Contact: Kathryn Hopkins, 500 Lansing Road, Charlotte, MI 48813 (517) 645-8050.

31-8/2, Michigan Academy of Family Physicians, 43rd Annual Scientific Assembly, Grand Traverse Resort, Acme, Contact: Julie Nelson, 109 East Oakland, Lansing, MI 48906 (517) 482-7410.

National Specialty Society Meetings

April

28, American Lung Association/American College of Chest Physicians, Annual Scientific Session: Diffuse Interstitial Lung Disease, Novi Hilton, Novi, Michigan, Contact: American Lung Association of Michigan, 403 Seymour Avenue, Lansing, MI 48933-1179 (517) 484-4541 or (800) 678-LUNG.

28-5/1, Association of American Physicians; American Society for Clinical Investigation, 1989 Annual Meeting, Sheraton, Washington, DC, Contact: Association of American Physicians, 660 S. Euclid Avenue, Box 8125, St. Louis, MO 63123 (609) 848-1000.

29-5/5, American Occupational Medical Association, Annual Scientific Meeting, Sheraton Boston, Boston, MA, Contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312) 228-6850.

30-5/3, American College of Physician Executives, National Conference on Health Care and Management, The Grand Hyatt, Washington, DC, Contact: (813) 287-2000.

May

3-7, American Psychoanalytic Association, 78th Annual Meeting, Hyatt Regency at Embarcadero Center, San Francisco, CA, Contact: American Psycoanalytic Association, 309 E. 49th Street, New York, NY 10017 (212) 752-0450.

6-9, National Conference on High Blood Pressure Control, Hilton Inn, Lake Buena Vista, FL, Contact: National Conference on High Blood Pressure Control, 4733 Bethesda Avenue #530, Bethesda, MD 20814 (301) 951-3275.

6-12, American Psychiatric Association, Scientific Meeting, San Francisco, CA, Contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005 (202) 682-6000.

7-10, American Association of Plastic Surgeons Annual Meeting, Camelback Inn, Scotsdale, AZ, Contact: American Association of Plastic Surgeons, The Johns Hopkins Hospital, 601 N. Wolfe Street, Harvey 811, Baltimore, MD 21205 (301) 669-7601.

7-11, American Urological Association Annual Meeting, Infomart/Loews Anatole Hotel, Dallas, TX, Contact: American Urological Association, 1120 N. Charles Street, Baltimore, MD 21201 (301) 727-1100.

8-10, American Association for Thoracic Surgery, Annual Meeting, Sheraton/Hynes, Boston, MA, Contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

11, American College of Emergency Physicians, Occupational Medicine, Holiday Inn Crowne Plaza, Atlanta, GA, Contact: American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911 (214) 550-0911.

MEETINGS

11-14, American Geriatrics Society; American Federation for Aging Research, 46th Annual Meeting, Marriott Copley Place, Boston, MA, Contact: American Geriatrics Society, 770 Lexington Avenue, Suite 400, New York, NY 10021 (212) 308-1414.

11-14, American College of Advancement in Medicine, 16th Annual Spring Conference: "Helping Patients Feel Better, Live Longer - Emerging Standards of Care for the 1990's", Hyatt Regency, Reunion, Dallas, TX, Contact: American College of Advancement in Medicine, 23121 Verdugo Drive #204, Laguna Hills, CA 92653 (800) 532-3688 or (714) 583-7666.

13-17, American Society for Gastrointestinal Endoscopy Annual Scientific Meeting, Sheraton Hotel, Washington, DC, Contact: American Society for Gastrointestinal Endoscopy, Thirteen Elm Street, Manchester, MA 01944 (617) 927-8330.

13-19, American Gastroenterological Association Annual Scientific Meeting, Sheraton Washington and Shoreham Hotels, Washington, DC, Contact: American Gastroenterological Association, 6900 Grove Road, Thorofare, NJ 08086 (609) 848-1000.

14-17, American Thoracic Society Annual Scientific Meeting, Convention Center, Cincinnati, OH, Contact: American Thoracic Society, 1740 Broadway, New York, NY 10019 (212) 315-8778.

21-23, American Society of Clinical Oncology, Annual Meeting and Exhibit Show, Moscone Center, San Francisco, CA, Contact: American Society of Clinical Oncology, 435 N. Michigan Avenue, Suite 1717, Chicago, IL 60611 (312) 644-0828.

22-25, American College of Obstetricians and Gynecologists, Annual Meeting, Convention Center, Atlanta, GA, Contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024 (202) 638-5577.

28-31, American Pediatric Surgical Association, Annual Meeting, Hyatt Regency Inner Harbor, Baltimore, MD, Contact: American Pediatric Surgical Association, Johns Hopkins Hospital, Baltimore, MD 20105 (301) 955-6256.

31-6/3, American College of Sports Medicine, Baltimore, MD, Contact: American College of Sports Medicine, P. O. Box 1440, Indianapolis, IN 46206- 1440 (317) 637-9200.

June

8-12, American College of Emergency Physicians, 18th Annual Scientific Assembly, Rancho Bernardo Inn, Rancho Bernardo, CA, Contact: American College of Emergency Physicians, 505 N. Sepulveda Blvd. #12, Manhattan Beach, CA 90266 (213) 374-4039.

11-15, American Society of Colon and Rectal Surgeons, Annual Meeting, Sheraton Centre, Toronto, Ontario, Canada, Contact: American Society of Colon and Rectal Surgeons, 615 Griswold, Suite 1717, Detroit, MI 48226 (313) 961-7880.

12-15, American Orthopedic Association, Annual Scientific Meeting, The Broadmoor, Colorado Springs, CO, Contact: American Orthopaedic Association, 222 S. Prospect Avenue, Park Ridge, IL 60068 (312) 823-7186.

13-16, The Society of Nuclear Medicine, Annual Scientific Meeting, St. Louis, MO, Contact: The Society of Nuclear Medicine, 136 Madison Avenue, New York, NY 10016 (212) 889-0717.

September

10-13, Society of Thoracic Surgeons, Annual Meeting, Convention Center, Baltimore, MD, Contact: Society of Thoracic Surgeons, 111 E. Wacker Drive, Suite 600, Chicago, IL 60601 (312) 644-6610.

10-14, American College of Radiology, Annual Meeting, Westin Hotel, Seattle, WA, Contact: American College of Radiology, 1891 Preston White Drive, Reston, VA 22091 (703) 648-8900.

11-14, American College of Emergency Physicians, Annual Scientific Meeting, Grand Hyatt Washington, Washington, DC, Contact: American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911 (214) 550-0911.

16-21, American Academy of Family Physicians Annual Scientific Meeting, Westin Bonaventure, Los Angeles, CA, Contact: American Academy of Family Physicians, 1740 W. 92nd Street, Kansas City, MO 64114 (816) 333-9700.

24-27, American Neurological Association, New Orleans, Contact: American Neurological Association, 2221 University Avenue SE, Suite 350, Minneapolis, MN 55414 (612) 378-3290.

24-28, American Academy of Otolaryngology — Head and Neck Surgery Annual Scientific Meeting, New Orleans, LA, Contact: American Academy of Otolaryngology — Head and Neck Surgery, 1101 Vermont Avenue, N.W., Suite 302, Washington, DC 20005 (202) 239-4607.

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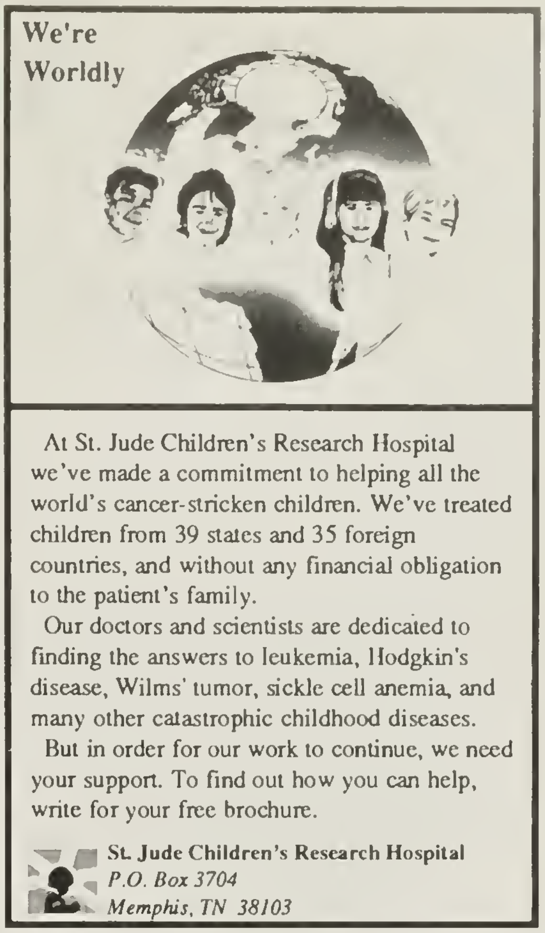
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PRESIDENT'S PAGE

One Thousand and One

By Fred W. Bryant, MD

Thirty five years ago, during the Korean conflict, I was an inquisitive Naval Lieutenant in the Far East. Japan has a "Temple of a Thousand and One Buddhas." To those who built and believed in the shrine, one thousand represented infinity; in creating this place of reflection and reverie, they sought to attain the infinite — and to surpass it! In our desire to excel, we tend to exaggerate and to reach out for the impossible.

The day I visited the shrine, a solitary craftsman was bent over, intent on refurbishing the second Buddha in line; his manner was meticulous and deliberate but agonizingly slow. Briefly I hesitated, gazing down the long row of figures stretching on interminably, pondering the enormity of the task of the tradesman and marveling at his enterprise. Only 999 more to go!

Then I moved on, passing in review, addressing each icon in turn, peering into dusty and enigmatic faces and noting hands poised in various positions of piety, strength and serenity — Buddha body English meant to represent desirable attitudes and characteristics of humanity.

In my travels around the state this year many have been curious about the consuming commitment of serving as MSMS president, sympathetic about the hours spent away from office practice, but to me this is a "given" — it goes with the territory. I wanted to get around during my term in office.

I'm like Evita, in the musical of the same name, at the end, tragically departing public life, singing to her followers, "Don't cry for me, Argentina." Buddha himself advocated extinction of self, and submersion in blissful enlightenment, located somewhere between the extremes of cupidity and accumulated tangibles on the one hand, and mortification (wounded pride, embarrassment over personal inadequacies, and frustrations with the world) on the other.

Many pleasant perks

Professional and public life have had pleasant perks for me. Some of the perks include the following:

(1) **The opportunity to practice medicine.** To me this is the premier profession, an ideal blend of science and art — challenging, inspiring and gratifying.. Public opinion concurs and, in general, approves of physicians.

(2) **The chance to wear white hats.** We should invariably be on the side of right — always the good guys. The profession is noble as are, with few exceptions, the practitioners. (Alas, even Jesus encountered an eight percent treachery-defection rate at the Last Supper, a burden he probably carried, along with the cross, to Calvary.)

(3) **The volunteer nature of the Society.** The soul of "organized medicine" is the cadre of willing and sincere physicians who give of themselves when they can, in clinics, committees, classrooms, and communities.

(4) **The privilege to compete in the democratic process,** the right to run for office in a representative system, and to be judged by peers, those best positioned to know and judge our attributes, and to render fair and wise decisions. T'was this that allowed me to view for the top honor of the Society, to "compete for the gold." And you obliged with the ultimate compliment, the presidency. I'll always be grateful.

(5) **The opportunity for rich and sparkling friendships.** When I was a lad, my father advised me to consider the professions as a career because of the quality of friends I would be likely to meet. My social horizon and circle of contacts has widened dramatically in the presidency. So many of you have been kind, warm, courteous, and considerate to me and my lady, Alma. We both thank you.

A good year for MSMS

I have tried to serve you with ardor, enthusiasm and good humor, evenly and fairly, from beginning to end. By my appraisal, this has been a good year for the Society with strong, positive attitudes, robust gainful activities, and little discord. In sum, a sanguine spirit in a salubrious climate with salutary results.

The end of this story is half a world away from its beginning in the Orient half a lifetime ago. Now I stand at the other end of the long row of Buddha, a route each of us must traverse, on the far side of infinity. A lifetime of service is its own reward. This artisan is soon to lay down the tools of his craft, hands folded in repose. But I will look back at the myriad faces and idealized postures of the past, some gold, some glitter, and some dust. Somewhere between ecstacy and eternity lie contentment and serenity, beside a lotus pool deep with memories and friendships. The ultimate. Nirvana. Infinity plus one!

Doctor Bryant is MSMS president.

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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema.* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension. Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function.* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASDTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension. Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE. As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension. Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C. There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use. Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 298/ patients.

Hypertension. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

Heart Failure. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (79%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation.

Digestive. Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric. Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy.

Respiratory. Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin. Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other. Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema. Angioedema has been reported in patients receiving VASDTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings.

Serum Electrolytes. Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen. In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASDTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown). In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests. Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASDTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASDTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASDTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia. In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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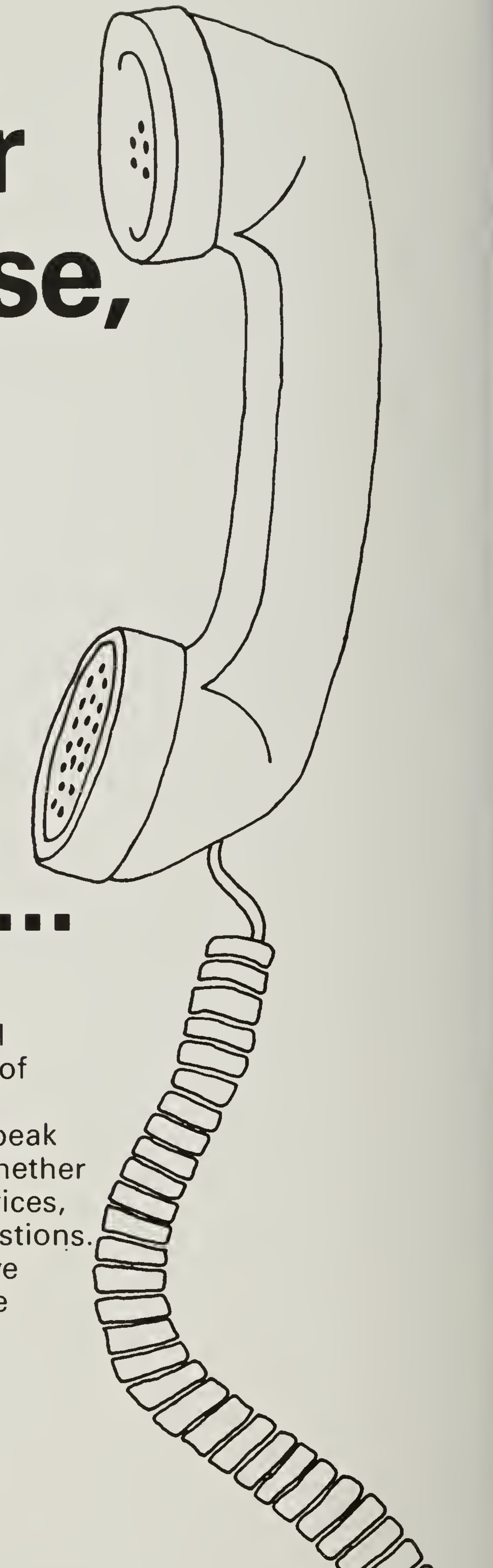

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Cover Story

MSMS is persistently working towards a solution to the professional liability problem in Michigan. In fact, finding a solution to the problem remains a top priority for MSMS. Research and data collection, emphasis on risk management, intensified interest in physician licensure and discipline, adequate tort reform, and attempts to find a series of alternatives are all part of the Society's strategy. The specifics of the Society's strategy, plus an update on the professional liability climate in Michigan, is the subject of this month's cover story.

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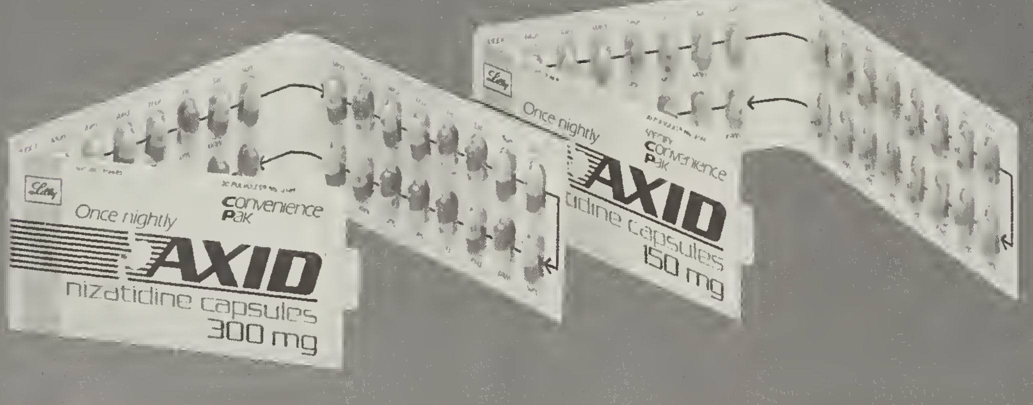

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AXID®

nizatidine capsules

Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects

CNS — Rare cases of reversible mental confusion have been reported

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Additional information available to the profession on request.

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[1] Data on file, Lilly Research Laboratories.

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IN MY OPINION

Professional Liability: Bank On Commitment, But Also On Fiscal Health

By Billy Ben Baumann, MD

Theodore Roosevelt's admonition to "do what you can, with what you have, where you are" applies to physicians struggling with the medical liability climate in Michigan.

Most physicians are doing what they can to ease liability problems, are working with organized medicine and their allies, and are staying in Michigan where the liability climate is considered one of the most turbulent in the nation.

When the Michigan State Medical Society (MSMS) tackled the liability crisis of the mid-1970s, perhaps there was more desperation than hope. But hope quickly surfaced. MSMS leadership created Michigan Physicians Mutual Liability Company (MPMLC), the state's only insurer exclusively owned by its physician policyholders.

Not enough is said about the "uniqueness" of MPMLC. As a mutual company, policyholders are the owners. If the company thrives, policyholders benefit. If economic or financial strength increases, the advantage and gain go to policyholders. MSMS created the company this way for good reason: Policyholders are owners and beneficiaries of company success. In other organizations, policyholders are customers; company success may benefit them, but owners and others with a financial interest in the company also benefit.

After its formation, and in keeping with its goal to benefit policyholders, MPMLC froze or reduced premiums from 1976 through 1981. Then the cost crisis of the mid-1980s came. It blew the financial drain plug and out poured the money. There was financial trauma — for physicians and MPMLC. Physicians grappled with a punishing wave of litigation and premium increases. Premium income and reserves set aside to pay future claims proved inadequate. MPMLC went on the financial solvency "cautionary," if not "critical," list.

Like worried relatives, MPMLC policyholders waited anxiously, concerned for themselves as well as the insurer on which they depended. The care, treatment, recovery and follow-up were what the doctors needed, if not ordered.

MPMLC's financial health has improved dramatically in recent years. It continues to progress toward full financial recovery. It's thriving anew as a source of pride to its founders, its policyholders, organized medicine and practitioners in this state.

Physicians must take a realistic view of liability protection needs, looking beyond premium cost and considering an insurer's long-term commitment as well as its financial strength.

Short-term gains should not overshadow long-term security. Buying your liability insurance purely on the basis of cost is short-sighted, and could be risky.

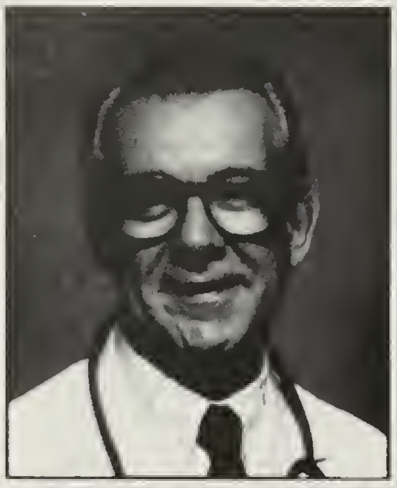
Be certain you can count on your insurer when the liability climate deteriorates. Be sure your insurer will have the resources to protect your professional and economic interests and that it will stay in business — in Michigan.

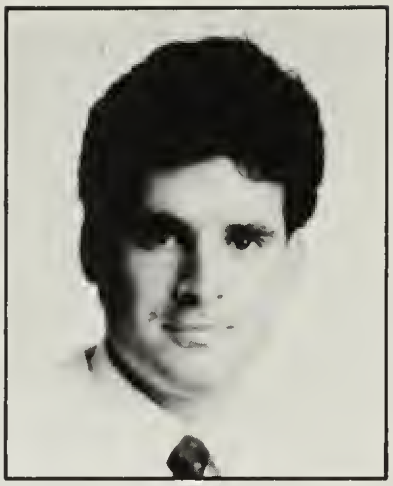
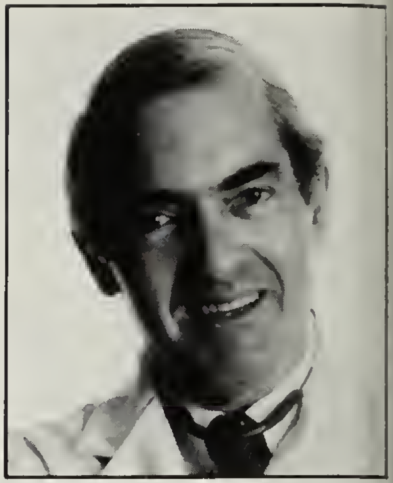
MPMLC's record of service and commitment is long-standing and certain. Its stabilized and improving financial strength is reassuring and promising to all.

Although some physicians have opted for alternative insurance programs and new entities, most have recognized the value of supporting and remaining affiliated with MPMLC, the largest insurer of physicians in this state.

The commitment between MPMLC and physicians is a "mutual" one. The stability and strength reflected in a financially sound MPMLC is a source of security for physicians and a major investment in the future for medicine in Michigan. ■

Doctor Baumann is MSMS treasurer and is a member of the MPMLC Board of Directors.



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If you're looking for alternatives, you may want to consider the Association Members Retirement Program for MSMS Members. For more information, simply fill out and mail the coupon. Just answer a few brief questions so that appropriate information for your particular needs can be forwarded to you.

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Letters from Our Readers

Read new Workers' Comp rules carefully

After reviewing the new Michigan Workers' Compensation rules and notifying the affected patients, I sent the following notice to two Michigan Workers' Comp carriers on April 27:

To: Michigan Workers' Compensation Insurance Carrier for

____

Social Security # ______________

This is to notify the appropriate Workers' Comp (WC) carrier that as of the date of implementation of the new Michigan WC rules, June 28, 1989, I will no longer serve as physician to the person named above. In the meanwhile, I will make reasonable attempts to transfer the case to a provider of similar professional certification.

My reason for discontinuing my services to the person named above is the lowered payment for services and increased requirements for reports to be prepared and provided without charge mandated in the new rules, with no balancing decrease in emotional and financial burdens of care provision and responsibility. The new rules are, to me, manifestly one-sided, inequitable, mindless and unconscionable, and indirectly harm the work-injured person and misrepresent the spirit of the Workers' Compensation Movement.

Failing reasonable attempts to find a medical practitioner willing to operate under the conditions I find unfairly burdensome to myself, I will instruct the above-named person to contact the WC carrier in order that the latter may discharge its responsibility to provide job-related injury treatment more directly. During gaps in care necessitated by this change in care providers, I will carry out whatever is necessary under law and medical ethics.

The main reason for this letter is to alert colleagues to read the new rules carefully. The second reason is to locate BC/BE psychiatrists, preferably in central Detroit, willing to accept the new standards. Call me at (313) 872-4720 or write me at 1060 Fisher Bldg., Detroit 48202.

Edward C. Dorsey, MD
Detroit

Physicians are becoming unpaid employees of insurance companies

I have just finished completing a letter to Blue Cross/Blue Shield of Michigan. This letter addresses a denial of one of my patient's claims which she received while still in the hospital. The denial involved Blue Cross/Blue Shield's refusal to pay for an admission of one of my patients who had recently "fell off the wagon" from a three-year abstinence from alcohol. This patient had been drinking for three days prior to her admission. She recognized her inability to stop on her own and sought admission into the hospital at this point. On the patient's second hospital day, she received a denial letter from our utilization review department at the instruction of Blue Cross/Blue Shield.

This is extremely upsetting to me because the patient didn't need this additional stress during this time in her life. I was also informed by the reviewing physician that if I had been giving her intramuscular injections or intravenous Librium, that she likely would have been approved. I refuse to alter the way I practice medicine because of an insurance company reviewing physician. The patient did reasonably well and was discharged home in satisfactory and improved condition.

I also resent the fact that time has to be taken away from my practice in arguing these points with the insurance company. I feel that we, as physicians in the state, are becoming unpaid employees of the insurance companies. I wonder if the situation might change if suddenly all physicians in Michigan were to start billing these insurance companies every time that we consult with them via the telephone or spend time composing letters for them on behalf of our patients. I have begun billing them for my time and await their reaction once they are turned over to small claims court.

It is my opinion that this unnecessary bureaucratic maze and failure to live up to their financial responsibilities has reduced the quality of health care. BCBSM has too much authority and no responsibility for subscribers health care. This trend must be reversed.

I also question whether or not the total health care expenditures have been substantially reduced under this new system with all the bureaucratic obstacles that have been introduced or whether there simply has been a shift of costs to the individual and physician.

Douglas L. Villa, MD
Diplomat,
American Board of Family Practice
Iron Mountain

Update on Pregnancy Prevention

The following is an excerpt of a letter Michigan Medicine editors received from Hoffmann-LaRoche, Nutley, NJ, regarding it Pregnancy Prevention Program for Women on Accutane.

As you may recall, Roche developed this far-reaching educational, labeling and packaging program last year in cooperation with the FDA and the dermatology community. The purpose is to reemphasize long-standing warnings that due to the risk of severe birth defects, Accutane must not be used by women who are pregnant or who may become pregnant while undergoing treatment.

Last August, the FDA approved revised labeling, which included six specific criteria that women must meet if they are to receive a prescription of Accutane. FDA also approved an unprecedented patient consent form to be signed by each female patient prior to receiving treatment. In mid-September, Roche began informing dermatologists and other Accutane prescribers nationwide about the program and our sales representatives began distributing our comprehensive Pregnancy Prevention Program kit to physicians to assist them with its implementation.

Last fall, Roche also established two toll-free 800 telephone numbers (one in English, the other in Spanish) for women to call for information about the risks associated with Accutane therapy.

We also have launched extensive educational programs on the Accutane pregnancy warning in conjunction with medical and professional organizations. This effort has included educational advertisements on proper prescribing which have appeared over the past seven months in publications directed at dermatologists and in other widely-circulated medical publications.

Our surveillance program, designed to provide information on how Accutane is being used by women of childbearing potential, is also underway.

Another important element of our program is the new packaging which Roche has designed to assure that every time the patient takes a capsule, she sees the pregnancy warning. Although we had anticipated launching the new packaging before now, we have experienced unforeseen technical problems. We expect to have these problems resolved shortly.

Please call me at (201) 235-5929, or Carolyn Glynn at (201) 235-3315 if you have any questions or if you would like to discuss any of this information in further detail.

Paula L. Frakes
Manager,
Public Policy and Communications
Hoffmann-La Roche

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Arthur B. Eisenbrey, M.D.
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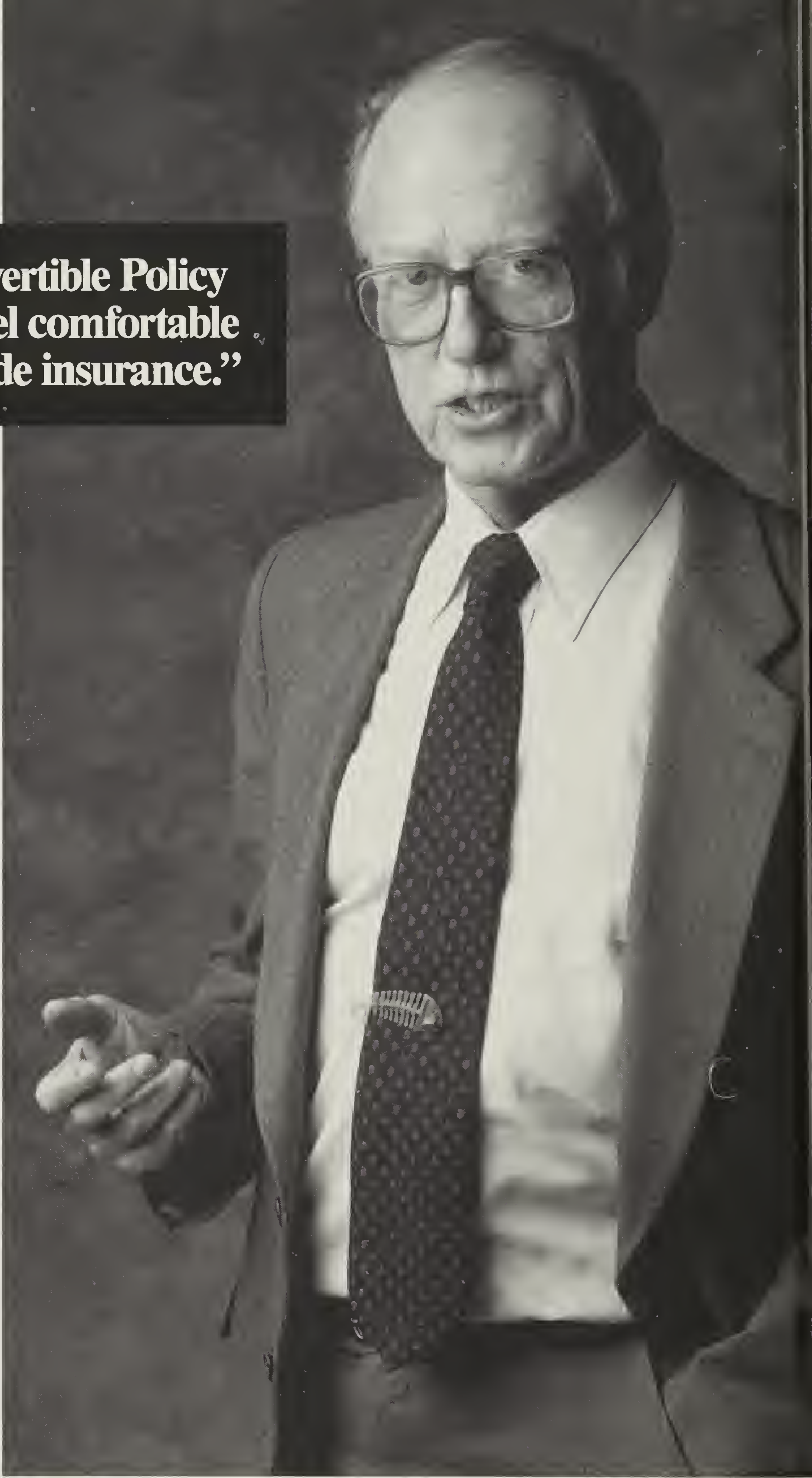
Now you can try claims-made insurance, even if you’re a skeptic. Call us or your PICOM agent for details.”



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MEDICAL NEWSFRONTS

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Community AIDS program receives grant

The Greater Detroit Area Health Council, Inc. (GDAHC) has received a two-year grant in the total amount of $822,200 from the W.K. Kellogg Foundation for the Coordinated Community AIDS Program (C-CAP) in southeastern Michigan.

C-CAP is a community-wide effort to deal with the tremendous economic and social costs of the AIDS epidemic. It is sponsored by GDAHC and United Community Services of Metropolitan Detroit, with close support from the eight local health departments in southeastern Michigan. More than 60 other organizations, including many hospitals and social service agencies, are also participants in the program. With this grant the W.K. Kellogg Foundation joins a funding coalition which includes the McGregor Fund and the Michigan Department of Public Health.

GDAHC will administer the two-year Kellogg grant in support of three major efforts:

(1) A community-wide case management system to link health and social services for persons with AIDS and those infected with the AIDS virus, will be designed and implemented. More than 15 community organizations are joining in this effort as part of the AIDS Consortium of Southeastern Michigan, Inc.

(2) The Wayne State University School of Social Work will receive assistance in preparing AIDS education and training for graduate and undergraduate students who will be providing counseling in a variety of health and community-based settings.

(3) Funds will also contribute to the management of C-CAP as it stimulates, coordinates and facilitates community programming, project development and the funding coalition.

According to Gerald Fitzgerald, GDAHC president and president of Oakwood Hospital, the number of people with AIDS or infected with the AIDS virus is expected to increase geometrically during the next decade. "The spread of this disease poses major clinical, social, cultural, political, human resources and economic dilemmas for our society," says Fitzgerald." The comprehensive and integrated set of projects, initiated by C-CAP, will help mitigate the tremendous social and economic costs while providing high quality, effective, and cost-effective services."

DMC opens new research building

The Louis M. Elliman Clinical Research Building of the Wayne State University School of Medicine is now open. The building was officially dedicated April 28. It is located at the corner of Canfield and Brush streets in The Detroit Medical Center.

The 100-square-foot Elliman Building houses about 50 laboratories and office space for medical researchers in neurology, cardiology, surgery, endocrinology, and pediatrics.

The $15 million building project was initiated in the spring of 1987 in response to a need to accommodate new research initiatives among school faculty. Research has nearly tripled at the school in less than a decade to its present base of $34 million annually.

The building is named for the primary benefactor, philanthropist Louis M. Elliman, who donated $1.5 million for the project. Elliman died in November 1987.

Soviet method revolutionizes orthopedic surgery at UM Med Center

A treatment developed in Siberia over the last 35 years is now being used successfully at the University of Michigan Medical Center to lengthen limbs, reconstruct shattered bones and correct congenital bone deformities.

The treatment, which combines virtually bloodless surgery with the temporary use of a limb-lengthening device called the Ilizarov External Fixator, has been used with dramatic results in the Soviet Union for nearly four decades. Since 1982, the technique has been practiced in Italy and other parts of Western Europe. Only recently was the Ilizarov technique introduced to the United States.

Since August 1988 the University of Michigan Medical Center has offered the treatment, which bears the name of its creator, Gavril Abramovich Ilizarov, MD, PhD.

The technique is offering orthopedic surgeons in the West a new understanding of the biology of bone growth. Until recently, the traditional approach to limb-lengthening was to cut the bone completely in half, pull the two halves apart and fill in the gap with bone chips from another part of the body or from a donor — a traumatic, invasive procedure that is often accompanied by severe complications.

The Ilizarov procedure differs from traditional limb-lengthening methods in that it requires no bone grafts. Instead, it capitalizes on the ability of bone to regenerate itself.

The Ilizarov treatment also requires one operation instead of several, and poses fewer complications, most of which can be dealt with fairly easily.

Because physical therapy is an important part of the overall treatment method, Ilizarov patients also are encouraged to be mobile within days of surgery, because activity of the affected area appears to accelerate new bone growth and healing.

Sinai Hospital awarded Skillman grant

The Speech Pathology and Audiology section of Sinai Hospital's Department of Rehabilitation Medicine will receive $60,000 from the Skillman Foundation to provide speech pathology services for needy children. The 18-month program will help children with speech and/or language disorders who are at high risk for developing learning disabilities.

The addition of a reading component makes this speech pathology program unique. The program will include training Sinai speech pathologists to deliver the reading and writing assessment tests and will test, treat and evaluate the children. Most of the funds will be used for therapy.

Program coordinator and speech pathologist Karen

Continued on page 10

Continued from page 9

O'Leary says, "Reading and writing problems in children are often misunderstood. These problems are usually attributed to visual perceptual problems when, in fact, reading and writing problems are based on difficulties with listening and speaking."

O'Leary adds that this program is aimed at children whose listening and speaking problems have already been diagnosed. The program will determine which course of treatment will best help the child.

The Skillman Foundation was founded in December of 1960 by Rose P. Skillman, widow of Robert H. Skillman, vice-president and director of Minnesota Mining and Manufacturing Company. The Foundation is a private, grant-making foundation headquartered in Detroit.

UM researchers receive $268,000 grant to study pain

What happens when people cannot avoid a physical activity despite great pain such as that resulting from jaw disorders? Eating and talking are no less painful for being unavoidable. Does the body adapt by shifting to use unaffected muscles?

Three University of Michigan researchers have received a $268,000 grant from the National Institute of Dental Research to study that question.

"Although the quality-of-life issue has generated a great deal of research in medicine, it remains a largely unexplored area in dentistry. However, the effects of oral facial pain are pervasive and have significant consequences for patients' quality of life," says Christian S. Stohler, UM associate professor of dentistry and chief investigator.

"We will study what sequence of events occurs as the central nervous system adapts to functioning in the presence of this pain," Stohler adds. "We hope to gain new insight into the effect of pain on jaw motor function."

Stohler's co-investigators at UM are James A. Ashton-Miller, associate research scientist in the College of Engineering; and David S. Carlson, professor of dentistry and research scientist in the Center for Human Growth and Development.

The researchers will study pain's effects in 80 persons — -40 with Temporomandibular Joint (TMJ) dysfunction and 40 with normal jaw function.

In the process they hope to develop a reliable, standardized model of experimental pain by studying what, if any, differences exist between acute pain induced by researchers and chronic pain caused by conditions like TMJ dysfunction.

WSU awarded patent for surgical glove

Wayne State University has been awarded a design patent for a cut resistant surgical glove. This innovation, conceptualized by Robert A. Welch, MD, and Mitchell P. Dombrowski, MD, of The Detroit Medical Center, is directed at reducing the risk of exposure to blood borne viruses, such as AIDS and hepatitis, due to inadvertent scalpel cuts during surgery.

The University's Intellectual Properties Office is entertaining all offers to license the marketing and manufacturing rights to this patent. Prototypes are in development. For more information telephone: Janet M. Bernardino at (313) 577-5600.

Institute for reconstructive surgery established

Providence Hospital, in affiliation with a group of physicians specializing in plastic and reconstructive surgery, has formed The Institute for Craniofacial and Reconstructive Surgery.

Internationally-renown physician Ian Thomas Jack-

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Physicians in the News

Charles J. Krause, MD, professor and chairman, Department of Otolaryngology, University of Michigan Medical Center, is the newly-named president of M-Care, Inc., the University's health maintenance organization. Doctor Krause, assistant dean for clinical affairs at the U-M Medical School, received his bachelor and medical degrees from the University of Iowa. He has received numerous honors and awards, including the Michigan State Medical Society National Presidents Award in 1982 and 1988 and the American Academy of Otolaryngology Honor Award in 1980. He has been president of the American Academy of Facial Plastic and Reconstructive Surgery and the American Society for Head and Neck Surgery. He is on the board of directors of the American Board of Otolaryngology and is secretary-treasurer of the American Academy of Otolaryngology — Head and Neck Surgery.

Eliezer Basse, MD, FACS, Pontiac, is the new chairman/medical director of the Emergency Center at Pontiac General Hospital. He is a graduate of Tel Aviv University, Sachler School of Medicine, Tel Aviv, Israel. Doctor Basse completed his surgical residency at Sinai Hospital of Detroit. Prior to accepting his new position at Pontiac General, he was an emergency department physician at Providence Hospital, Southfield.

I. Richard Weiss, MD, a Kalamazoo physician, is now certified by the American Medical Society on Alcoholism and Other Drug Dependencies as an addiction physician.

Robert H. Burke, DDS, MD, Ann Arbor, is the new president-elect of the American College of Oral and Maxillofacial Surgery. The college consists of over 1200 surgeons who are board certified in head, neck, and related specialties. A fellow of the college since 1982, Doctor Burke also chairs several national committees. He will assume his new post for a term of two years. He will continue as chairman of the orthognathic surgery standardization, the temporomandibular joint standardization, and the membership committees for the college.

William Abbett, PhD, East Lansing, is the new acting dean of the College of Human Medicine, Michigan State University. The executive assistant to the dean, Doctor Abbett will maintain the College's program and act upon the initiatives set by Doctor Weston until a new dean is found. A search committee for a new dean is being formed. In the meantime, says Doctor Abbett, the College will focus on such issues as its commitment to minority and female students and staff members; building the clinical component of the college; moving forward with curriculum development initiatives and expanding community relationships.

Silas Cheuk, MD, an Oakwood Hospital physician, is a new inductee to the International Heritage Hall of Fame. For the past 12 years, Doctor Cheuk has provided free monthly medical check-ups to elderly Chinatown residents. It is this dedication to the members of his ethnic community for which he is being honored. He was chosen for the honor by Friends of the International Institute. He is the first person of Chinese descent to be inducted into the International Hall of Fame. The International Heritage Hall of Fame is showcased in a permanent exhibit at Cobo Hall.

Michael Iacobellis, MD, PhD, Riverview, is assuming the position of chief of medical staff at Oakwood Hospital. Doctor Iacobellis has served as chief of staff-elect since 1986 and has been a member of the Medical Staff since 1963. He will continue to operate his private family medicine practice in Dearborn. Doctor Iacobellis attended the University of Bari Medical School in Italy and the University of Michigan. He earned his PhD in physiological chemistry in 1953 and his medical degree in 1961 from the Wayne State University School of Medicine.

Harold E. Bowman, MD, professor of pathology, Michigan State University College of Human Medicine, is chairman of the Professors of Clinical Oncology Committee for the American Cancer Society. He also is a new member of the Unproven Methods Chairman's Work Group, a national committee which works with the Food and Drug Administration to determine which drugs are efficacious for treatment of cancer.

J. Maxwell Cook, MD, Lansing, has retired from his post as Ingham County Medical Examiner and Director. He earned his medical degree from the University of Michigan Medical School and held a private practice in Lansing. He helped Sparrow Hospital establish its emergency room in the 1960s. In 1978 he began his work as the medical director. Under his direction, the health department grew from one health clinic open two hours a week, to four clinics open 40 hours a week.

M. Joseph George, MD, Farmington Hills, is the newly-elected president of the National Association for Ambulatory Care, Michigan Chapter. He has served on the Association's board since 1985. Doctor George is the director of three walk-in medical centers and is a co-director at Kingswood Urgent Medical Center. He is on staff at Pontiac General Hospital and directs the advanced cardiac life support program at St. Mary's Hospital, Livonia.

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son, MD, FRCS, FACS, formerly head of the plastic surgery section for The Mayo Clinic in Rochester, Minn., will join the Institute as director and a principal consultant and surgeon.

With a multi-disciplinary faculty of leading specialists, the Institute will provide comprehensive consultation, diagnosis, treatment and follow-up for clinical cases requiring craniofacial and reconstructive interventions. Specialists will offer services including craniofacial and plastic surgery, neurosurgery, microsurgery, otorhinolaryngology, ophthalmology, orthodontics, prosthodontics, oral surgery, and pediatrics.

The Institute for Craniofacial and Reconstructive Surgery will emphasize a team approach to patient care, integrating consultation and treatment from all areas of surgery and medicine associated with a particular case. In addition to surgical specialists, the Institute will use the skills and talents of speech pathologists, child and adult psychologists, geneticists, social workers, and nursing professionals to take part in the patient care teams.

As a part of its comprehensive care, the Institute plans to help organize accommodations and transportation for patients from other states and countries, when possible and appropriate. Already, cases are being referred from Great Britain, Canada, Italy, Saudi Arabia, Australia, India, and Germany.

Other principal physicians for the Institute are Hashim M. Alani, MD, FRCSE, FACS, and Judith K. Perigo, MD, whose Southfield surgical practices also are affiliated with Providence Hospital. The specialties of the principal doctors include hand, breast, cleft palate, head and neck cancer and aesthetic reconstructive operations, as well as Doctor Jackson's work in craniofacial surgery which encompasses congenital deformity, trauma, and skull-base tumors.

Additional physicians will be recruited for the Institute as planning and organizational efforts develop. The Institute also is in the planning stages of offering post-graduate fellowships in craniofacial surgery as well as active research programs.

Persons interested in the Institute, or who need information on craniofacial and reconstructive surgery, should call (313) 424-5800.

Toll-free hotline offers information on cholesterol

Cholesterol is a hot topic in the media and on bestseller charts. And patients everywhere are asking doctors about taking niacin as a treatment.

Current studies report that niacin therapy can lower blood cholesterol levels. But for which patients and at what doses? What possible side effects should be monitored, and how can they be minimized?

Doctors can now call a toll-free hotline offered by the Niacin Information Center, a new service exclusively for health professionals. The number to call for up-to-date, reliable information on niacin is 1-800-NIACIN-1.

Upon request, doctors will receive the National Heart, Lung, and Blood Institute's report on the use of niacin in lowering blood cholesterol. Extensive references on niacin and patient-education materials will also be provided.

The Niacin Information Center is provided as a public service by Lonza Inc., the world's leading manufacturer of niacin.

New device may help pinpoint causes of migraine headaches

Neurologists at Henry Ford Hospital, in collaboration with medical physicists at Oakland University, have unveiled a sophisticated new device that may, for the first time, help pinpoint the causes of migraine headaches.

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The device – called a Neuromagnetometer – is one of only 16 in the world manufactured by Biomagnetic Technologies, Inc., San Diego, Calif. Henry Ford Hospital is the only research center using the Neuormagnetometer to study migraines.

"Migraines are a major social and economic problem affecting almost 10 percent of the population," says K. Michael Welch, MD, chairman of the department of neurology at Henry Ford. "New techniques that provide a window to the brain during this disabling disorder will bring us much closer to a position where we can combat the condition."

For years, some doctors believed that migraine headaches were caused by an altering of the brain's electrical activity, but there was no way to measure the information needed to prove their theory. The Neuromagnetometer now provides researchers with an accurate means of gathering this important information.

The device uses a measurement technique called magnetoencephalography (MEG) to tract the very weak magnetic fields which are generated by electrical currents inside the brain. The harmless procedure is painless and can last anywhere from 20 to 60 minutes. Subjects are placed inside a spacious 18,000-pound room made of Mu-metal and aluminum – alloys that literally soak up interfering magnetic signals emitted from the environment. A large probe is placed over the head and measurements, gathered simultaneously from seven different points outside the skull, are recorded.

By comparing data received from patients suffering from migraines with data from normal patients, doctors may be able to determine what factors are responsible for causing the debilitating headaches.

UM Med School receives $100,000 grant from Maas Foundation

The Benard L. Maas Foundation, Ann Arbor, has given a $100,000 grant to The University of Michigan Medical School to provide fellowships to outstanding students in basic sciences.

"The importance of the basic sciences to medical research cannot be underestimated," says Joseph E. Johnson III, dean of the UM Medical School. Recruiting high-caliber graduate students is crucial to maintaining excellence in the School's biomedical research program, he says.

"The single most pressing problem we face in attracting the very best students is the level of fellowship support we are able to offer," says Doctor Johnson. "Even with an outstanding faculty and first-class facilities, it remains necessary to have fellowships competitive with those of peer institutions. The establishment of the Maas Fellowship will enable us to attract outstanding students whose work may well influence future developments in medical science. We are deeply grateful for the Foundation's support."

Oakland Diagnostic receives CAP accreditation

Oakland Diagnostic Laboratory, Southfield, has been awarded a two-year accreditation by the Commission on Laboratory Accreditation of the College of American Pathologists (CAP), based on results of a recent on-site inspection. The lab is one of the more than 4,000 CAP-accreditated labs nationwide.

The CAP Laboratory Accreditation Program is one of the few recognized by the federal government as requiring adherence to standards equal to or more stringent than the government's own.

Michigan State Medical Society

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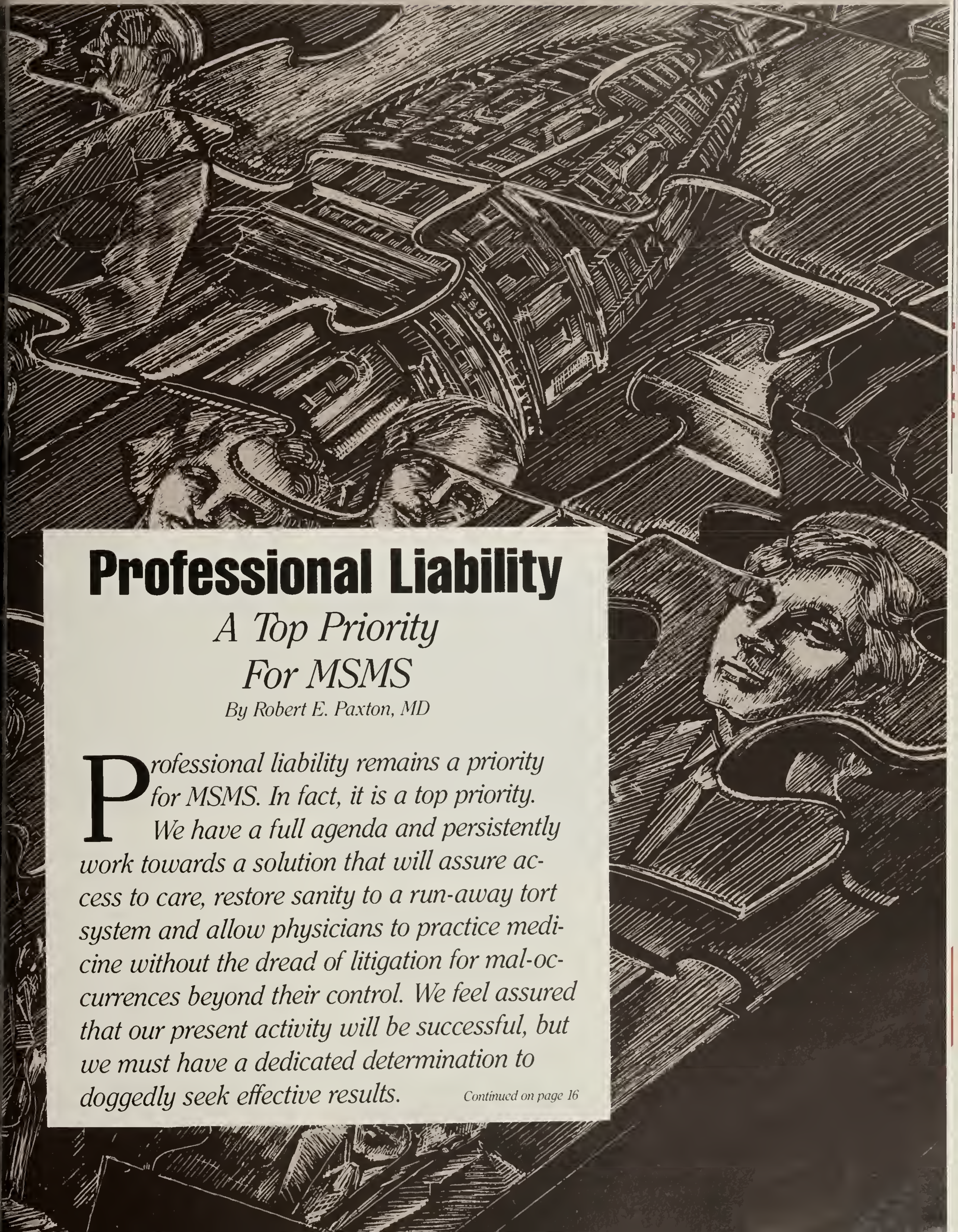
Cover Story



Professional Liability

A Top Priority For MSMS

By Robert E. Paxton, MD

Professional liability remains a priority for MSMS. In fact, it is a top priority. We have a full agenda and persistently work towards a solution that will assure access to care, restore sanity to a run-away tort system and allow physicians to practice medicine without the dread of litigation for mal-occurrences beyond their control. We feel assured that our present activity will be successful, but we must have a dedicated determination to doggedly seek effective results.

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To introduce the subject in this issue of *Michigan Medicine*, I would like to briefly enumerate our strategy.

1. **Research and data collection** with an ongoing accumulation of facts that illustrate the affect of the liability crisis on access to care and quality of care.

2. **Emphasis on risk management** with the eventual establishment of a full-time MSMS department dedicated to the subject. We will work cooperatively with the liability insurance companies and the Michigan Hospital Association to achieve both physician and patient education with constant emphasis on quality care.

3. **Intensify interest in physician licensing and discipline.** Currently, we are cooperating with Speaker Dodak's special legislative committee, chaired by Representative David Gubow, that is looking into the current system for disciplining physicians to find improvement or to recommend scrapping the system and instituting one similar to that used by the State Bar.

4. **Continue to seek adequate tort reform** to establish a more equitable and fair system with prompt and adequate claim settlement for the truly injured. But there are problems with tort reform. It is the opinion of the Tillinghart Corporation that the only tort reforms that reduce premiums are a strict cap with no exceptions and shorter statute of limitations.

In addition, we are well aware of the difficulty there is in achieving effective tort reform in Michigan. We are also aware that throughout the nation, most effective caps have been declared unconstitutional. Nevertheless, we are pursuing additional legislation to further modify the tort system by jury. These bills include a cap without exception by death, damage to female reproductive organs or loss of vital bodily function. We wish to lower the statute of limitations for children from 13 to 15 years down to a more reasonable six to eight years limit. We are seeking stricter qualifications for expert witnesses and the right to counter sue. We also are considering the legislative route for limitation of the contingency fee.

5. **The heart and soul of our efforts are embodied in attempts to find a series of alternatives** that could resolve the problem in Michigan. We have been working with the Michigan Hospital Association to develop a product that would be an administrative, at-fault system similar to the AMA/Specialty Society concept. We have also initiated the recommendation set forth by the Health Policy Agenda for the American People and are seeking a possible solution to unusual cases such as neurologically damaged newborn babies with a no-fault system.

Arbitration remains a viable part of our solution with legislation mandating arbitration as an option in certain health care insurance products and alternative health care delivery systems available to the public.

This summer we are taking part in a trip to Sweden with all of the principal actors in the liability drama. Our plan is to fully evaluate and discuss together Sweden's no-fault system that includes physician discipline for incompetence. Finally, we are currently involved in the activity of the Governor's Task Force to evaluate alternatives to tort by the jury system, which is headed by Robin Fleming, MD.

After reading this, you may ask how alternatives can be the essential part of our liability program when you hear from varied authorities that all these plans will only add to the cost of the problem. I will admit that this is a common danger of all such plans. However, given the political and judicial climates in our state, plus the runaway litigious attitude of the public, alternatives are the only long-range answer we have. Remember, we are committed to certain principles that are necessary if any plan is workable.

1. We must limit provider contribution so it is reasonable and locked into increases only on the basis of inflationary change.

2. Secondly, there has to be sharing of cost by the public to keep a reasonable cap on what is paid out.

3. There has to be defined benefits to any plan with a definition of predetermined injuries.

Our long-range goal is to have a combination of workable proposals ready to go by the end of 1990. From that point on, we can push for implementation of our program.

While we are in the process of developing that program we will fight each skirmish with enthusiasm. To insure victory, we consistently need a total commitment by MSMS members, staff and leadership. Hopefully, we can see results like our pension plan protection legislation which happened only because of a total, unified effort.

I remain optimistic and feel certain that some form of solution will be forthcoming. While we are working towards that end, our immediate task is to keep the politicians and the public constantly aware that the problem is still with us and desperately needs solutions! ■

Doctor Paxton, MSMS president, is chairman of the MSMS Professional Liability Task Force.

Cover Story

Pension Protection

Legislation Enacted

By Richard D. Weber

Qualified retirement plan assets are now protected from collection proceedings. The Michigan legislature enacted the legislation on April 6 and the Governor signed the bill on April 19. Passage of the legislation was an MSMS priority.

Although the statute covers qualified plans for all segments of society, its application is of particular significance to physicians. A physician's major assets are often held in a qualified retirement plan. The assets are the result of years of financial planning and devotion to the practice of medicine. Without this statutory protection, retirement plan assets could be lost to a judgment creditor as the result of a single incident.

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The complex application and interpretation of federal and state laws, which placed retirement plans at risk and led to this legislation, are not within the purview of this article. Suffice it to say, lack of malpractice insurance because of outrageous premiums or unavailability, coupled with the typical limits of $200,000, resulted in continued jeopardy to physicians' qualified retirement plans.

Act 5 exempts Michigan qualified retirement plans from collection proceedings. It applies to pension, profit sharing, stock bonus, or other plans qualified under Section 401 of the Internal Revenue Code, or an annuity contract under Section 403 (b) of the Internal Revenue Code. Physicians' qualified retirement plans are included in the broad protection afforded under the Act.

Three exemptions

There are three exemptions to the statutory protection:

(1) To the extent the plan assets are subject to an order of a court pursuant to a judgment of divorce or separate maintenance;

(2) To the extent the plan assets are subject to an order of a court concerning child support; and

(3) To the extent of any amounts contributed to the plan within 120 days before the debtor files for bankruptcy.

Opponents of the legislation vigorously pursued an additional exception which would have conditioned any protection upon the existence of liability insurance. The insurance requirement amendment was vigorously opposed by MSMS on legal and policy grounds. It was defeated in the legislative committee process.

In order for retirement plan assets to be protected, the plan must be "qualified" under the Internal Revenue Code. This qualification requirement imposes built-in annual contribution limits. Excess contributions would disqualify the plan and thus eliminate the plan from the statutory protection. The maximum contribution an individual may make to a defined contribution plan is $30,000 per year. The maximum contribution an individual may make to a defined benefit plan is determined on an actuarial basis. This requires a focus upon the future benefit payout. In general, the limit on contributions to a defined benefit plan is an amount that will not yield a benefit in excess of $90,000 per year at age 65. This amount is reduced actuarially if retirement before age 65 is allowed. The calculation is complicated and it is not the purpose of this article to cover this point in detail.

Further protection

The Act provides further protection for assets "rolled over" from a qualified plan to an individual retirement account. Often, upon retirement or other termination from employment, a retirement plan participant rolls over his/her interest from a qualified plan to an individual retirement account. The assets rolled over retain the same statutory protection in the individual retirement account as was provided in the qualified plan. On the other hand, annual contributions to an individual retirement account are not protected by the legislation to the extent the contributions to the individual retirement account are not deductible under the Internal Revenue Code. Individuals who have qualified plans begin to lose their IRA contribution deduction when their income exceeds $25,000 per year, and completely when their income exceeds $35,000 per year. For joint returns, these income thresholds are $40,000 and $50,000 per year. Therefore, the statutory protection will not benefit most physicians' individual retirement accounts. Nevertheless, individual retirement account assets are generally substantially less than qualified retirement plan assets. The maximum limitation on individual retirement account contributions are $2,000 per year per employed person, or $2,250 per year per married couple where only one spouse is employed.

Protection effective immediately

The Act, which takes effect immediately, amends the Revised Judicature Act. It does not affect a cause of action for malpractice or other tortious conduct. It simply establishes an exemption to collection proceedings. Therefore, the protection afforded by the Act should apply to all pending claims or cases. In that sense, the Act should have retroactive effect and apply to existing claims which have not been reduced to final judgment and collection proceedings.

Michigan physicians can now rest easier. This law provides comfort to physicians concerned about preserving their hard-earned retirement nest egg. In view of the liability crisis and our litigious society, this is a significant achievement. ■

Richard Weber, MSMS legal counsel, is an attorney with Kerr, Russell and Weber, Detroit.

Cover Story

The voice of organized medicine is being heard, thanks to MSMS

By Robert E. Paxton, MD

Just about two years ago, the MSMS Board of Directors decided organized medicine's voice, particularly in the area of medical liability, was not being heard over the roar put up by other organizations.

To help get our message out, the Board decided to undertake a concerted strategy to talk to the people who present the news to the people of Michigan: newspaper editors, radio broadcasters and television anchors.

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Since the implementation of this "media blitz" in October, 1987, MSMS leaders have made over 300 personal contacts with members of the media to present organized medicine's view on the medical liability crisis.

Subsequently, dozens of editorials have been written supporting our positions. The most dramatic was one by *The Detroit Free Press* in November, 1987. Carl A. Gagliardi, MD, and Charles C. Vincent, MD, and I went to *Free Press* Editor Joe Stroud's office and explained that despite the 1986 tort reform package, a medical liability crisis still existed in the state of Michigan. Joe Stroud said to us, "What do you want done about it?"

At that time, MSMS had three immediate goals: to look again at the trust fund; to pass legislation to protect pension plan assets; and to have the governor appoint liability factfinders to consider alternatives to the tort system.

The *Free Press* ran an editorial supporting all three of our goals and the same day, the speaker of the Michigan House of Representatives called then-president Doctor Gagliardi and said "Let's talk."

Since then, the trust has been reviewed thoroughly and although at this time it appears to be a dead issue, we at least fulfilled our political obligation and had the review we asked for. Better news is that not too long ago, the governor appointed Robben Fleming and Jay Rosen to take another look at the medical liability situation in Michigan and to evaluate alternatives to tort by jury. And the best news is that the Governor recently signed the pension protection bill into law.

The good news about our new media relations is that when we present our case in a reasonable tone with facts to back up our arguments, the people who control the media will listen and support us. We have kept the liability issue on the front burner in the legislature and in the mind of the public because of the help from our friends in the media.

The bad news is that we must do more media contact at a time when many physicians still fear working with the media. Let me try to assure you; 99 percent of the time the media is friendly, honest and concerned. They represent their readers, viewers or listeners, who also happen to be your patients. As long as you keep in mind that the liability crisis is most adversely affecting the patients and present your arguments on that basis, you will have the ear of the media.

During my term I hope to visit the media as much as possible to continue to present the facts about the liability crisis in light of the effects it has on the people of Michigan.

Please take notice now, that if I am in your area, I might call on you to give me a hand.

In the meantime, talk to your local media representatives. You are a respected member of the community. They will listen to you.

If you would like tips for talking with the media, contact David Fox, Chief, Media Relations, in the MSMS Department of Communications and Professional Relations. ■

Doctor Paxton is MSMS president and is chairman of the MSMS Professional Liability Task Force.

MSMS
to participate in seminar on Sweden's medical malpractice system

By Kevin A. Kelly

Cover Story

Continued discontent with the American approach to resolving medical malpractice problems has generated interest in alternative approaches and models. One such alternative is the system functioning in another modern, industrialized advanced country with a high standard of living, high technology medical care and medical education similar to the United States. The country: Sweden.

A seminar will be held in Stockholm, Sweden, August 13 to 23 which will provide an overview of the various components of the Swedish medical malpractice system. The system is a voluntary one and does not preclude recourse to the courts.

In addition to representatives from MSMS, those planning to attend the Stockholm seminar include representatives from the following groups: the Governor's office; Senate and House leaders Michigan Hospital Association; Michigan Hospital Association Mutual Insurance Company; Michigan Michigan Physicians Mutual Liability Company; Michigan Trial Lawyers; Physicians Insurance Company of Michigan, and Public Sector Consultants.

Background material and general information for the seminar will be provided by Professor Marilynn M. Rosenthal, author of the 1988 book, *Dealing with Medical Malpractice: The British and Swedish Experience.* She will be attending the seminar.

The seminar will highlight a unique feature of the system — the Patient Insurance Fund — from which compensation is based on a predetermined schedule of compensable injuries. Minor injuries, psychological injuries and injuries arising from well-known risks are excluded. The seminar also will review the Swedish Medical Responsibility Board, an independent government agency which reviews complaints against physicians and has disciplinary powers.

Finally, the seminar will look at the initial steps taken in the Swedish system to feed back information from the Patient Insurance Fund and Medical Responsibility Board records to hospitals and practicing physicians. The Medical Responsibility Board (MRB), a free-standing national governmental body supported by public

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taxes, receives complaints about all health professionals, but approximately 80 percent concern physicians. The Board is supported by an administrative staff of 20 who screen the complaints. Those with merit are investigated by a physician with training and expertise similar to the physician named in the complaint.

Seminar participants will be meeting with Carl Oldertz, director of the Skandia Insurance Company, who will describe the Swedish Patient Insurance Fund. He has been asked to describe the history and features of the Swedish Patient Insurance Fund, the appeals process, research findings and the mechanism for providing information feedback to the medical profession.

Seminar participants also will be meeting with Ingemar Nygren, executive director of the Medical Responsibility Board (MRB), which is Sweden's licensure and discipline entity. In sessions with both Ingemar Nygren and members of the MRB, participants will be briefed on the staff resources available to the MRB, how the staff investigates a case, current problems, systems for getting the information back to the medical providers, how members are appointed and what changes may be contemplated for the MRB in the future.

The seminar also will include a series of discussions on the origins and philosophy of the Swedish Patient Insurance Fund. MSMS representatives hope to discuss: how the representative parties/organizations were convinced to agree on the patient insurance approach; the general Swedish approach to personal injury; and how well the current system is working.

Seminar participants also will make site visits to assess the quality assurance and risk management programs in Swedish urban and rural hospitals.

The seminar will provide all participants with an opportunity to critique a viable patient insurance fund mechanism, which has an integrated licensure, discipline and risk management system.

It is anticipated that research and analysis of the alternative system will spark an authentic discussion on what aspects of our current tort system may need changing in order to improve the medical liability climate in Michigan.

The relative success of the Swedish approach suggests that it can stimulate fresh ideas and approaches for adaptation to the United States and Michigan. ■

Kevin Kelly is assistant director of MSMS.

Cover Story

Berrien County Medical Society

A Leader in Medical Malpractice Mediation

By Chad B. Munger

Mediation, as an alternative to trial by judge or jury, has been a largely unpopular method of solving medical malpractice suits. Legislation enacted in 1986, which is now beginning to take effect around the state, promotes the use of physician-assisted mediation as a tool to change Michigan's disturbing medical malpractice climate.

Michigan's first medical malpractice mediation panel to include physicians was established in cooperation with the Berrien County Medical Society (BCMS) in 1988. Since their inception a year-and-a-half ago, physician-assisted mediation panels have been used in three separate cases in Berrien County and numerous times in other counties around the state. This new approach to mediation is viewed as a positive step by those who have taken part. However, many physicians still are wary of becoming directly involved with an issue that has had so many negative implications for their profession, as one Berrien County physician attests:

"I think most doctors are scared to death of the legal system," says Gerald Beal, MD, a Berrien County internist who has twice served on a mediation panel. "The aspects of medical liability have become so complex they are bewildering. The idea of getting involved in a whole new system is frightening."

Michigan's "new system" for handling medical malpractice suits came about as a result of the tort reform legislation of 1986. This legislation, which was put into effect by the Michigan Supreme Court in June of 1988, requires physician participation in all mediation involving medical malpractice suits. It also requires that all medical malpractice suits be mediated. This legislation is an attempt to reduce the massive volume of malpractice liability cases in Michigan by providing an opportunity to settle out of court.

A more acceptable option

The promise of large jury awards and an underlying suspicion of an attorney's ability to make legal judgments about the practice of medicine often has made mediation a less desirable alternative to a lawsuit. It is the intent of the new legislation, which introduces changes in both the form and function of mediation panels, to make malpractice mediation a more acceptable option by including physicians in the award decision.

Changes in the mediation process, outlined by the high court's interpretation of the new legislation, focus on panel membership and responsibilities. In the past, mediation panels presiding over medical malpractice cases consisted of three members, all attorneys. The new Michigan statute requires five-member panels, each consisting of three attorneys and two health care professionals. One health care professional is chosen by each side, but both must practice in the same or related relevant field as the defendant.

The controversial aspect of this requirement is that both the plaintiff and defendant must appoint a physician representative. Immediate concerns over the conflict of interest arising from physicians aligning themselves with one party or the other have been eliminated, at least in Berrien County, by creating a list of physicians available to serve. The list does not differentiate between those willing to represent either the plaintiff or the defendant.

Frank Bunker, MD, a member of Michigan's inaugural physician-assisted mediation panel, says that when the Berrien County Medical Society met with area judges to discuss establishing a list of phy

Continued on page 20

Continued from previous page

sicians willing to participate in the process, it was made quite clear that physicians would not align themselves with one side or the other. "We are not willing to be identified as representatives of the plaintiff or the defendant," states Doctor Bunker. "We realize we may be contacted by either party, but we are not beholden to them."

Before physician-assisted panels were in place, it was common for decisions to be rejected by both the physician and the plaintiff. The addition of physicians to the panel, who have experience in the defendant's field of practice, make both the plaintiff and defendant more at ease with the panel's decision. Second District Court Judge Casper O. Grasswell, also a "veteran" of two physician-assisted mediation panels in Berrien County, says that "what we're finding is that a doctor, as well as the plaintiff, is much more willing to accept a mediation award when other physicians are involved in the mediation decision."

Supreme Court guidelines

Guidelines handed down from the Supreme Court also define the responsibilities of the mediation board, requiring them to arrive at one of three findings regarding the applicable standard of care provided by the defendant. The panel may find that: (1) the applicable standard of care has been breached; (2) the applicable standard has not been breached; or (3) that reasonable minds could differ as to whether or not a breach has occurred. The presence of physicians gives these findings a significantly greater amount of weight in the minds of both the plaintiff and the defendant.

Further concerns about physician participation in mediation include a fear that loyalty to their profession might prevent objective decision making. Concerns over intra-professional bias between physicians, at least in Berrien County, have proven to be unfounded. "We tried to wipe our minds as clean of professional bias as we could," explains Doctor Beal, "and I feel that we could be quite fair about the decision." Judge Grasswell agrees, "Doctors seem to have been very objective in their decision making. They are willing to call a spade a spade."

Reactions from everyone involved in the mediation process have been very positive, Doctor Beal says. "I think physician involvement in mediation is a great idea. I truthfully hope that it develops into something totally worthwhile instead of deteriorating into less than serious input from physicians. Time will tell and I'm all for it."

The objective of reaching mediation awards that are acceptable to all parties involved, and consequently reducing the volume of malpractice suits tying up the Michigan judicial system, seem to be attainable, but only with the cooperation of physicians. The mediation process is time consuming, as it requires at least a full day out of the office in addition to time for reviewing background material. Physicians are reimbursed by both parties, but at a level which does not even approach the income sacrificed by giving up a day in the office. This fact, and a tendency to shy away from direct involvement in the legal system, may be the greatest barriers to full physician cooperation.

The Berrien County Medical Society has proven that these problems are not prohibitive and that the new approach can work, but it requires initiative and leadership on the part of organized medicine. BCMS has emerged as a leader in Michigan for supplying physicians to mediation panels by directing a vigorous and successful campaign to enlist physician services at mediation hearings. Almost half of the BCMS active members have made themselves available for this duty. It is this type of participation that is required to make mediation a viable alternative to spending time in court. ■

Chad B. Munger is an East Lansing-based freelance writer.

Cover Story

Physician Contact *With Legislators Important*

By Daniel R. Farhat

In order to be true representatives of the people, legislators need to know the thinking of their constituents on the issues upon which decisions will be made. A significant part of Michigan's legislative agenda includes issues that directly affect the current practice of medicine in Michigan. Because of this attention, it is extremely important that physicians individually establish direct contacts with their state legislators.

Personal contacts can be a meaningful way to influence the decisions of a state legislator. Physicians can establish these contacts by writing and/or calling their district legislators to discuss concerns on health-related issues. Remember, legislators are not experts on all of the issues they address. Therefore, information and input by physicians aid legislators in their decision-making process. It's easy and effective.

When writing a letter to your state legislators, it is best to use the following format:

State Senator
The Honorable (Full Name)
State Capitol
Lansing, MI 48913
Dear Senator (Last Name):

State Representative
The Honorable (Full Name)
State Capitol
Lansing, MI 48913
Dear Representative (Last Name):

Remember to provide as much factual information as possible when raising concerns on issues. Specific information and details aid the legislator in debate among colleagues.

Direct personal contacts also can be an effective tool for influencing the decisions of legislators. Make an effort to personally meet with your state legislators. Get to know them on a one-to-one basis. Usually, legislators are back in the home district on Mondays and Fridays.

Take a moment to call your state legislators and arrange a meeting in the district. Continue to meet with them occasionally throughout the year. Soon you will have established yourself as an invaluable resource to those legislators. At this time, you will have positioned yourself to effectively influence their decisions on health care issues.

If you need any assistance in obtaining the names, addresses, and phone numbers of your state legislators, or background information on specific issues, please feel free to contact the MSMS Department of Government Relations. ■

Daniel R. Farhat is Chief of Political Affairs for MSMS.

Cover Story

Special House Committee

to examine licensing and discipline procedures

By Mary Kay Scullion

The new House Special Committee on Physician Licensure is considering some difficult and important questions — questions which affect the ability of physicians to practice medicine, as well as the public's right to quality health care.

Rep. David Gubow (D-Huntington Woods) is chairing the Special Committee which was appointed by Speaker Lewis N. Dodak (D-Montrose). The speaker has asked the Committee to examine current licensing and discipline procedures to determine what, if any, changes may be necessary to improve the quality of health care.

The Committee's direction from the Speaker is to review current practices with regard to allopathic, osteopathic, and podiatric physicians. While the charge of the Committee is relatively broad, there are two issues which it will not be specifically addressing: medical malpractice, at least as it relates to tort reform, and insurance affordability and availability.

At the Committee's inital meeting, Rep. Gubow noted that the Committee was not formed to, nor would it, place blame for alleged "bad doctors." He also noted that there is no preconception of the Committee's outcome. While most of the attention has focused on the possibility of adopting a model similar to that used by the State Bar for self-licensure and discipline, the Committee members are open to discussion of that approach but are not at this time committed to adopting it.

The Committee members began their deliberations with a detailed presentation by the Department of Licensing and Regulation (L&R). That presentation included a review of current statutory and administrative rules provisions affecting licensing; information concerning the numbers, types, and sources of complaints against physicians; the investigation and hearing processes and information concerning the recently formed medical malpractice unit. After the L&R overview was completed, the Committee next heard testimony from each of the professional associations.

Perhaps the most interesting presentation to date was made by four individuals who are part of the credentialing/peer review process at Clinton Memorial, St. Lawrence, Henry Ford, and Beaumont hospitals. In each instance, the representatives were able to provide a perspective based on both the size of the facility and the status of physicians, i.e. private practitioners with staff privileges or medical corporation employees. Describing the peer review process as the "front line" of the effort to ensure quality health care, the presenters provided an overview of the process which hospitals are required to fulfill as well as insight into the problems they have in sharing information with other hospitals and/or the licensing boards.

Future committee meetings are scheduled to hear presentations from the state licensing board members; malpractice insurance carriers; the State Bar and Michigan Trial Lawyers; the Attorney General; and other licensed health care professionals who are part of the medical treatment process. Also scheduled are a presentation on licensure and discipline in other states and a discussion on the role of the doctor in monitoring and reporting on performance by his or her peers.

To date, a number of issues have arisen which will require further discussion and/or research by the Committee members and their staff. Those issues are:

■ The role of the attorney general in licensing and disciplining physicians.

■ The lack of data sharing and access to peer review records between hospitals and between hospital and L&R.

■ The lack of consumer awareness of how to complain about physicians and what to complain about. (Most consumer complaints involve allegations of impairment, sexual misconduct or overbilling.)

■ The lack of confidentiality of the disciplinary process in contrast with the State Bar process.

■ Whether or not there ought to be grounds for automatic revocation or suspension or licenses.

■ How disciplinary action is reported to hospitals and patients.

■ The question of whether or not a self-licensing model constitutes an impermissible delegation of powers.

Committee members intend to continue meeting on a bi-weekly basis until the summer recess. At that point, they will be able to determine the next steps in the process of developing recommendations for action. ■

Mary Kay Scullion is senior research analyst for the Michigan House of Representatives.

Risk Management

An Important Choice for Physicians

By Thomas R. Berglund, MD

Cover Story

Negatives still abound in medical professional liability; we continue to face troubling and costly issues. Yet, we have survived the crisis in many respects. Many positives are emerging or expanding:

- Perhaps today, more than at any other time, there is greater understanding of litigation's impact on society, not just on physicians.
- More people outside the medical profession and medical liability insurance industry better appreciate what most of us have been saying since the mid-1970s.
- Some of the political, economic and turf wars between physicians and hospitals have subsided.
- Most physicians remain active in a private practice mode. Over-zealous intrusion into the private practice of medicine may be leveling off.

Although medical practice is still changing and there are divergent views on how physicians should handle their business, economic and professional activities, we've not been relegated to pawn status. Physicians still have choices they can make in many aspects of their clinical practices.

Risk management has surfaced as one of the most important choices physicians have. Government, the insurance industry and organized medicine all support risk management activities as a way to minimize the economic and human consequences of medical liability.

Good risk management can reduce liability. Reduced liability can restrain inflationary pressure on the cost of liability insurance. Restraint in premiums can alleviate medical costs. Patient care or satisfaction can be enhanced. This transcends noblesse oblige. It's become mandatory for professional and economic survival.

MSMS-MPMLC partnership

The Michigan State Medical Society (MSMS) and Michigan Physicians Mutual Liability Company (MPMLC) are cooperating to make it easier for physicians to pursue risk management. They're jointly sponsoring special half-day seminars in various Michigan communities through August.

Some programs already have been held — in Lansing, Kalamazoo, Grand Rapids, and Port Huron. Following are the dates and locations of the remaining programs (all of which will be conducted from noon to 5 p.m.):

- June 1, Holiday Inn, Traverse City.
- June 14, Holiday Inn, Alpena.
- July 19, Holiday Inn, Marquette.
- July 27, Bay Valley, Bay City.
- August 9, Wayne County Medical Society, Detroit

To register, or for seminar information, contact: Richard Campau or David Fox at MSMS (517) 351-1351.

A long-standing commitment

MSMS and MPMLC have long been committed to programs and efforts to benefit physicians and their patients. These jointly-sponsored risk management seminars attest to that commitment.

Key components of the risk management seminars include an overview of risk management; written and oral communications and their impact on liability; legal implications of the medical record; and preparing for a lawsuit. A significant feature of the seminars is a question-and-answer session.

Exposure to risk management concepts and discussions is important. That exposure should be periodic, reinforced and revisited. Repeated exposure to risk management is a practical way to avoid or minimize liability exposure — an ever-present danger.

No easy answers

Risk management certainly is no panacea for our liability concerns. But, as I have noted in the past, it can help physicians to do the following:

- Anticipate pre-existing or emerging clinical pitfalls.
- Deal with, or head off, unrealistic patient expectations.
- Identify personality and other non-clinical factors that might trigger a dispute or liability claim.
- Handle high-risk cases and conditions.
- Identify appropriate procedures for referrals, consultations, and similar patient relations issues.
- Work through a maze of legal issues.

Added protection

When physicians choose to engage in risk management programs and activities, they extend their professional liability protection. Risk management supplements malpractice insurance.

MPMLC is giving premium credits to physicians who choose to participate in approved risk management programs. The MPMLC-MSMS joint programs are facilitating that choice.

Physician choice always has been important to the medical community — and to MPMLC. In addition to offering risk management choices, MPMLC continues to give physicians a choice in liability protection.

New choices on the horizon

MPMLC is developing some new choices for physicians — for risk management and for liability insurance protection.

In many respects, MPMLC has status as "the company of choice." It was chosen as a solution to the liability insurance crisis of the mid-1970s. MPMLC chose to organize as a mutual insurer — making policyholders its owners. MPMLC gives physicians a choice of liability coverage plans, and is working to expand those choices. ■

Doctor Berglund is president of MPMLC and secretary of MSMS.

MSMS
MPMLC

Risk Management Seminars Teach Physicians How to Avoid Unnecessary Lawsuits

By Betty J. McNerney, Managing Editor

More than 60 physicians attended the first MSMS/MPMLC Risk Management Seminar held on March 29 in Lansing.

To date, more than 200 physicians have attended an MSMS/MPMLC risk management seminar since the series began in March. Of the nine seminars slated for various locations throughout the state, four have already been held. Dates and locations of the remaining seminars are as follows:

June 1 - Port Huron - Edison Inn
June 14 - Alpena - Holiday Inn
July 19 - Marquette - Ramada Inn
August 9 - Detroit - Wayne Co. Medical Society

While there is much for physicians to learn about effective risk management, the MSMS/MPMLC seminar helps make the task easier. First of all, thanks to the Stratton-Cheeseman Management Company, seminar attendees are provided with an extremely well-organized notebook on the "how tos" of effective risk management — something each physician can take back to the office and share with his/her staff.

In addition to the notebook, an MPMLC risk management consultant offers a variety of insights on the topic, as well as answers to any questions attendees may ask.

For those who are curious about the kinds of information the MSMS/MPMLC seminar offers, *Michigan Medicine* presents the following highlights of the first MSMS/MPMLC seminar held March 29 in Lansing.

Risk management defined

The Lansing seminar began with a definition of risk management given by Rebecca Sue Armato, MPMLC risk management consultant, who led the seminar. "It is the process of making and carrying out decisions that will minimize the adverse effects of accidental losses upon organizations," she said.

Six key components

Next, Armato identified and discussed the six key components to effective risk management: (1) Office policies and procedures; (2) patient communications; (3) patient confidentiality; (4) medical records; (5) informed consent; and (6) termination of the physician/patient relationship.

As for **office policies and procedures**, Armato said: "The physician has the greatest potential to control liability exposure in the office setting." Yet, approximately 30 percent of malpractice claims originate in physician offices.

Patient perception of the office environment is very important, Armato continued. The physical structure of a physician's office, its atmosphere, how the staff communicate between themselves and patients are all important.

"A patient who has had a good experience will tell four people about it," Armato said. "A patient who has had a bad experience will tell nine."

Written policies and procedures are vitally important, according to Armato, and should encompass four areas: (1) personnel; (2) business office practices; (3) patient care; and (4) emergencies.

Patient/staff communications plays a very important role in effective risk management, Armato said. "Physicians and staff must be courteous with patients on the phone. Patients who are angry will find a reason to sue the physician."

Receptionists often spend their day diagnosing patients over the phone, said Armato. Strict guidelines as to who talks to whom and what they can and cannot say or do are a necessity.

Several tips regarding patient communications are provided in the notebook prepared by Stratton-Cheeseman. Areas covered in the notebook include: appointment scheduling; communication during the office visit; handling the dissatisfied patient; telephone communications; and patient education.

Confidentiality is the basis of trust in the physician/patient relationship, Armato told attendees. "Communications occuring as a result of this relationship may not be disclosed to other persons without the express written consent of the patient. This includes verbal statements and written communications that relate to the patient and his/her care."

Medical records are the best defense in a lawsuit, Armato said. "The only thing a judge or jury looks at is that which has been documented."

Informed consent is the process by which a patient receives information about a recommended procedure or treatment, Armato told attendees. "The quality of the education the patient receives during this process directly affects the ability to make an informed decision to consent to or refuse the procedure."

Armato pointed out that "it is the responsibility of the physician who will be performing the procedure to obtain the patient's informed consent prior to the event."

Terminating the physician-patient relationship is "an area physicians are all too lax on," Armato said.

Detailed information on the above six key components of effective risk management is provided in the seminar notebook.

Also speaking at the seminar was Jeffrey H. Chilton, attorney for Kitch, Saurbier, Drutchas, Wagner & Kenney, PC, Lansing, who discussed strategies for "Preparing for a Legal Battle."

For more information on the remaining MSMS/MPMLC risk management seminars, contact with Richard Campau or Dave Fox at (517) 337-1351.

Rebecca Sue Armato, risk management consultant, MPMLC, discussed the key components of effective risk management at the seminar.

Jeffrey H. Chilton, attorney, Kitch, Saurbier, Drutchas, Wagner & Kenney, PC, Lansing, discussed strategies of "Preparing for a Legal Battle."

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Michigan Conference on Maternal & Perinatal Health
HIGHLIGHTS

The 28th Annual Michigan Conference on Maternal and Perinatal Health, held March 22-23, at the Dearborn Hyatt, drew approximately 600 physicians, nurses and other health care professionals. In addition to several scientific courses and exhibits, the two-day conference featured a "stump the panel" session on perinatal decision-making.

Photos by Pattrick Yockey

Members of the Planning Committee for the Michigan Conference on Maternal and Perinatal Health were responsible for judging poster presentations at the conference. Shown above (l to r) are: David R. Calver, MD, Bloomfield Hills; John R. Addy, MD, Lansing, co-chairman; Steven M. Donn, MD, Ann Arbor, co-chairman; Kate Larkin, RN, Troy; and Daniel J. Wilhelm, MD, Port Huron. Of the 17 posters presented at the conference, three earned awards. Cash prizes were given to one author in each category of nursing, obstetrics and pediatrics.

Approximately 28 organizations exhibited at the Conference. Representatives of the exhibiting firms were on hand throughout the two-day event to offer samples of their products, informational brochures and to answer questions. Pictured above center are three representatives of the McNeil Consumer Products Co.

MICHIGAN
CONFERENCE
ON

Charles C. Vincent, MD, chief, Department of Gynecology, Hutzel Hospital/Detroit Receiving, and chairman, Michigan Board of Medicine, discussed "Substance Abuse: Crime, Cost and Maternal/Perinatal Health," during the first General Session held Wednesday morning.

Conservative Management Of Mi
Amniocentesis Fluid Leakage

John R. Addy, MD, (left), Lansing, and Steven M. Donn, MD, Ann Arbor, conference co-chairmen, congratulate Robin B. Gold, MS, of Sinai Hospital, Detroit, obstetrics poster awardee, for her poster, "Conservative Management of Trimester Post Amniocentesis Fluid Leakage."

Co-chairmen Addy and Donn congratulate Donna M. Lyons, BSN, RNC, Wayne State University School of Medicine, nursing poster awardee, for her poster, "Patient Education Materials: Incongruence With Patient Reading Levels."

Linda K. Zak, MD, of the Department of Pediatrics and Communicable Diseases, Section of Newborn Services, U-M Medical Center, pediatrics poster awardee, is congratulated by co-chairmen Addy (left) and Donn for her poster, "Management of Unusual Thoracic Air Leaks Using High-frequency Jet Ventilation."

MICHIGAN
CONFERENCE

J. Devn Cornish, MD, assistant professor, Department of Pediatrics, University of California-San Diego School of Medicine, discussed the "State of the Art in Neonatology" during the General Session Wednesday.

Bonnie Flood-Chez, RNC, MSN, perinatal clinical specialist/consultant, and president, Nursing Education Resource, Secaucus, NJ, discussed two topics at the Conference: "Pitfalls in Fetal Monitoring," and the "Legal Issues" concerning obstetrics.

Carl Cohen, PhD, professor, Department of Philosophy, and Director, Human Values in Medicine, University of Michigan Medical School, addressed attendees on the "Moral Issues Presented by New Reproductive Technologies."

MSMS Section For Graduates Of Foreign Medical Schools

FIRST ANNUAL MEETING HIGHLIGHTS

Seventy-five delegates elected by their hospitals to attend the first annual meeting of the MSMS Section for Graduates of Foreign Medical Schools applauded as their concerns found their first dedicated forum in organized medicine. The meeting was held March 17-18 in Dearborn.

Approximately 100 Michigan physicians who are graduates of foreign medical schools gathered in Dearborn March 17-18. They met to participate in the first annual meeting of the newly-forming MSMS Section for Graduates of Foreign Medical Schools.

They acted on 21 resolutions submitted for their consideration, chose a slate of officers to form the Section Governing Council, heard addresses by national leaders, and enjoyed a dinner featuring international cuisine and entertainment.

Named first chairman of this first medical society Section for Graduates of Foreign Medical Schools in the nation is Busharat Ahmad, MD, Marquette ophthalmologist. Named vice chairman is Krishna K. Sawhney, MD, Detroit surgeon. Other new officers are Vicente Gracias, MD, Grand Rapids, secretary-treasurer; Samir Yahia, MD, Detroit, delegate to the Michigan State Medical Society; Allan C. D. Brown, MD, Ann Arbor, alternate delegate; Jose Evangelista, MD, Livonia, and Byung Lee, MD, Mt. Clemens, members-at-large.

Doctor Ahmad emphasized to the delegates that they could make a difference by participating in organized medicine and "in cooperation with our US-graduated medical colleagues."

"Our enemies are not the US graduates," he said. "We have to fight regulations, liability insurance problems and other forces which encroach upon our ability to practice medicine in the best interests of our patients.

"Let's remember," he continued, "we are not Filipinos or Indians or Pakistanis or Koreans or US graduates — we are all in it together. Our fate is in our hands, and not anyone else's. What we do, how much we do, and how we do it will make a difference. This is a democratic country, and participation is the name of the game."

The GFMS Section delegates, elected by their hospital medical staffs, approved eight resolutions of the 21 submitted. They referred another two to their Governing Council for further study. Those resolutions thus continued call for:

1) MSMS to invite the General Accounting Office to discuss its study on discrimination against graduates of foreign medical schools with MSMS and Section leaders, and for MSMS to offer assistance on the study.

2) MSMS to develop a data bank on available residencies after matching, and to make the information available to all interested parties.

3) MSMS to study Michigan graduate medical education programs with regard to acceptance of graduates of foreign medical schools, and establish a program to assist and educate graduates of foreign medical schools on the application and interviewing process used in obtaining post-graduate training in Michigan.

4) The Michigan delegation to the AMA ask the AMA to support federal legislation banning discrimination against graduates of foreign medical schools.

5) MSMS to recommend that the AMA encourage more involvement of graduates

Busharat Ahmad, MD, Marquette, first chairman of the new Section's Governing Council, told the delegates they could make a difference by participating in organized medicine, and by cooperating with their US-trained medical colleagues.

AHMAD
BRYANT
NELSON
MELNICK

At the head table during opening ceremonies of the two-day meeting were, from left, MSMS President Fred W. Bryant, MD, Royal Oak; AMA President-elect Alan Nelson, MD; Donald E. Melnick, MD, senior vice president, National Board of Medical Examiners, and Krishna Sawhney, MD, vice chairman, MSMS Section for Graduates of Foreign Medical Schools.

of foreign medical schools in its policymaking, and that MSMS encourage graduates of foreign medical schools to become more involved in the AMA.

6) A major goal of the new Section is to reach and educate all physicians of the existence of the section and issues concerning graduates of foreign medical schools.

7) MSMS establish public speaking and communications skills workshops for interested members.

8) MSMS facilitate involvement of graduates of foreign medical schools in American medical education and research.

The Section delegates called on their Governing Council to formulate guidelines for improving the efficiency and quality of care in future medical missions; to study reorganization of the Section through the county medical societies, and to encourage approval of a fifth pathway to licensure in Michigan.

Alan R. Nelson, MD, president-elect of the AMA, was keynote speaker. He began his remarks by addressing two key concerns of Michigan graduates of foreign medical schools: 1) The AMA's refusal to establish a national section for graduates of foreign schools, and 2) The AMA's lack of support for federal legislation to prohibit discrimination against graduates of foreign medical schools.

As to the first, he reminded the Michigan physicians that the AMA Board does support the need for a national section, and that it was the AMA House of Delegates that turned down their call for a Section. He reiterated the delegates' reasons — primarily that many did not see the need for a Section. "For those of us who were in favor of an FMG section before the House defeated it," he said, "let me go on record that we hope what you do here . . . will be a great success. You have the opportunity here to develop a section that will serve as a worthy model for what other states can do."

The bills opposing discrimination, he said, "still call for imposing federal control over medical licensure. And so AMA leadership cannot support these bills. Our position on these bills is a matter of state's rights — really. We believe strongly that federal legislation pre-empting state regulations would open the way to federal licensure of the practice of medicine. And that is something we do not want to happen."

He praised the Michigan physicians for their dedication to working within the system, and exhorted them to work together. "Beyond the difficulties you often have, "think about the other issues . . . that concern all physicians practicing in this country today." He cited specifically five enduring professional goals: 1) To ensure professional authority "commensurate with our responsibility." 2) To ensure equity and fairness in reimbursement. 3) To ensure full due process in all review. 4) To ensure the freedom to make clinical decisions without being forced into conflict of interest situations. 5) To obtain relief from the malpractice crisis. ■

Doctor Nelson described the AMA's stance regarding graduates of foreign medical schools, and called on the Michigan physicians to think about issues that concern all physicians practicing in this country today.

Doctor Melnick reported the Board hopes to phase in a universal licensing examination for all medical graduates, regardless of the location of their training, beginning in fall, 1991.

Palma Formica, MD, chairman, AMA Council on Longrange Planning, predicted there eventually will be an AMA Section for Graduates of Foreign Medical Schools. A graduate of a medical school in Rome, she reminded the Michigan physicians that they will play a large role in determining whether that happens.

MSMS
HOSPITAL MEDICAL STAFF SECTION

MEETING HIGHLIGHTS

Above: *Fifty-nine delegates, alternate delegates, MSMS officers and guests gathered March 11 at the Ritz Carlton Hotel, Dearborn, for the Fifth Assembly Meeting of the MSMS Hospital Medical Staff Section. Attendees were visibly concerned with the issues discussed at the meeting as shown above. Among the many topics discussed at the meeting were Michigan AIDS legislation, the Good Samaritan Law, and future predictions for hospital medical staffs in the 1990s.*

Left: *Senator John J.H. Schwarz, MD (at podium), was one of eight featured speakers at the meeting. Senator Schwarz discussed a bill he is sponsoring in the state legislature that would extend the Good Samaritan law to physicians rendering care in emergency rooms.*

The Fifth Assembly received and deliberated on 22 resolutions, considered amendments to its Constitution and Bylaws, and reelected four of its officers. Re-elected were: Gary D. Maynard, MD, chairman; Devendra Sharma, MD, vice chairman; Gerhard C. Endler, MD, secretary; and Peter A. Duhamel, MD, at-large member.

William R. Fifer, MD, a nationally known hospital consultant, was the featured luncheon speaker. In his presentation, "The Hospital Medical Staff of 1999," Doctor Fifer predicted that the medical staff of 1999 will "be heavily involved in marketing and strategic planning" and will be responsible for "exploiting the superiority of specific services offered by other hospitals."

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- ▶ the fastest turnaround and claims payback of any system available.
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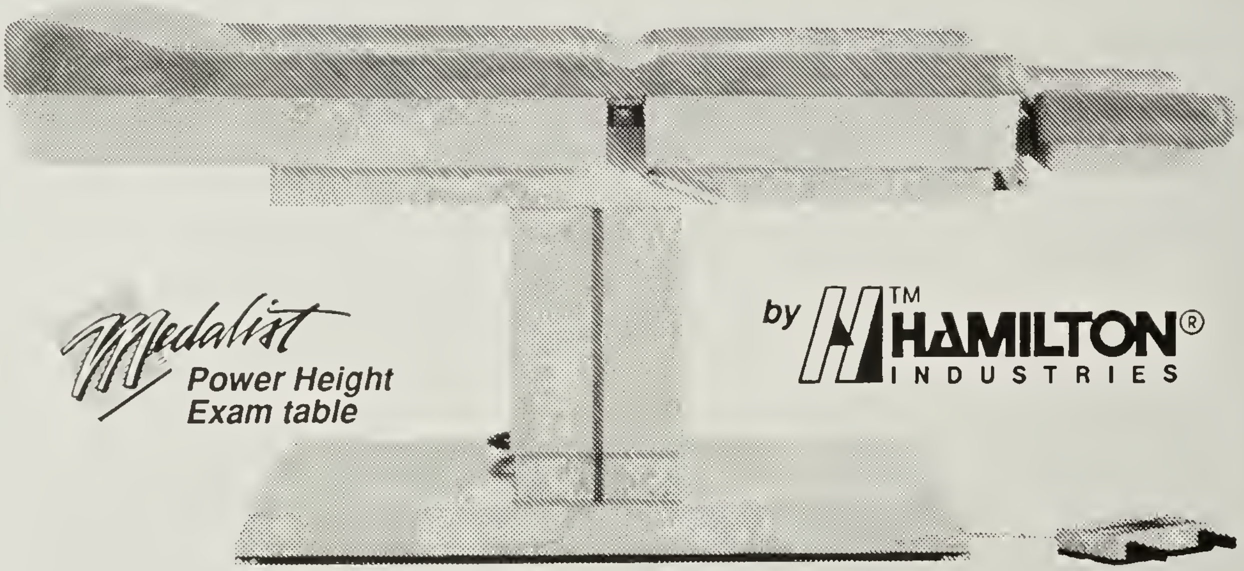

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(diltiazem HCl) sustained release capsules

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Helps prevent end-organ complications[7,8]

Helps reduce cardiovascular risks[2,5,9]

90 mg SR bid

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Please see brief summary of prescribing information on next page.

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*Dosage must be adjusted to each patient's needs, starting with 60 to 120 mg twice daily.

BRIEF SUMMARY
CARDIZEM® SR
(diltiazem hydrochloride)
Sustained Release Capsules

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), (4) patients who have demonstrated hypersensitivity to the drug, and (5) patients with acute myocardial infarction and pulmonary congestion documented by x-ray on admission

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (nine of 2,111 patients or 0.43%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt) Experience with the use of CARDIZEM (diltiazem hydrochloride) in combination with beta-blockers in patients with impaired ventricular function is limited Caution should be exercised when using this combination.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** Mild elevations of transaminases with and without concomitant elevation in alkaline phosphatase and bilirubin have been observed in clinical studies. Such elevations were usually transient and frequently resolved even with continued diltiazem treatment In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions tended to occur early after therapy initiation (1 to 8 weeks) and have been reversible upon discontinuation of drug therapy The relationship to CARDIZEM is uncertain in some cases, but probable in some (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated, but available data are not sufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50% If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a 1-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day Ranitidine produced smaller, nonsignificant increases The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine An adjustment in the diltiazem dose may be warranted

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Anesthetics: The depression of cardiac contractility, conductivity, and automaticity as well as the vascular dilation associated with anesthetics may be potentiated by calcium channel blockers. When used concomitantly, anesthetics and calcium blockers should be titrated carefully

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers. Diltiazem is excreted in human milk One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded from these studies.

The adverse events described below represent events observed in clinical studies of hypertensive patients receiving either CARDIZEM Tablets or CARDIZEM SR Capsules as well as experiences observed in studies of angina and during marketing The most common events in hypertension studies are shown in a table with rates in placebo patients shown for comparison. Less common events are listed by body system, these include any adverse reactions seen in angina studies that were not observed in hypertension studies In all hypertensive patients studied (over 900), the most common adverse events were edema (9%), headache (8%), dizziness (6%), asthenia (5%), sinus bradycardia (3%), flushing (3%), and 1° AV block (3%). Only edema and perhaps bradycardia and dizziness were dose related. The most common events observed in clinical studies (over 2,100 patients) of angina patients and hypertensive patients receiving CARDIZEM Tablets or CARDIZEM SR Capsules were (ie. greater than 1%) edema (5.4%), headache (4.5%), dizziness (3.4%), asthenia (2.8%), first-degree AV block (1.8%), flushing (1.7%), nausea (1.6%), bradycardia (1.5%), and rash (1.5%)

DOUBLE BLIND PLACEBO CONTROLLED HYPERTENSION TRIALS

Adverse	Diltiazem N=315 # pts (%)	Placebo N=211 # pts (%)
headache	38 (12%)	17 (8%)
AV block first degree	24 (7.6%)	4 (1.9%)
dizziness	22 (7%)	6 (2.8%)
edema	19 (6%)	2 (0.9%)
bradycardia	19 (6%)	3 (1.4%)
ECG abnormality	13 (4.1%)	3 (1.4%)
asthenia	10 (3.2%)	1 (0.5%)
constipation	5 (1.6%)	2 (0.9%)
dyspepsia	4 (1.3%)	1 (0.5%)
nausea	4 (1.3%)	2 (0.9%)
palpitations	4 (1.3%)	2 (0.9%)
polyuria	4 (1.3%)	2 (0.9%)
somnolence	4 (1.3%)	—
alk phos increase	3 (1%)	1 (0.5%)
hypotension	3 (1%)	1 (0.5%)
insomnia	3 (1%)	1 (0.5%)
rash	3 (1%)	1 (0.5%)
AV block second degree	2 (0.6%)	—

In addition, the following events were reported infrequently (less than 1%) o have been observed in angina trials. In many cases, the relation to drug is uncertain.

Cardiovascular: Angina arrhythmia, bundle branch block, tachycardia, ventricular extrasystoles, congestive heart failure, syncope.
Nervous System: Amnesia, depression, gait abnormality, hallucinations, nervousness, paresthesia, personality change, tinnitus, tremor abnormal dreams
Gastrointestinal: Anorexia, diarrhea, dysgeusia, mild elevations of SGOT, SGPT and LDH (see hepatic warnings), vomiting, weight increase thirst.
Dermatological: Petechiae, pruritus, photosensitivity, urticaria.
Other: Amblyopia, CPK increase, dyspnea, epistaxis, eye irritation, hyperglycemia, sexual difficulties, nasal congestion, nocturia, osteoarticular pain, impotence, dry mouth.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. Definitive cause and effect relationship between these events and CARDIZEM therapy cannot yet be established.

Issued 1/89

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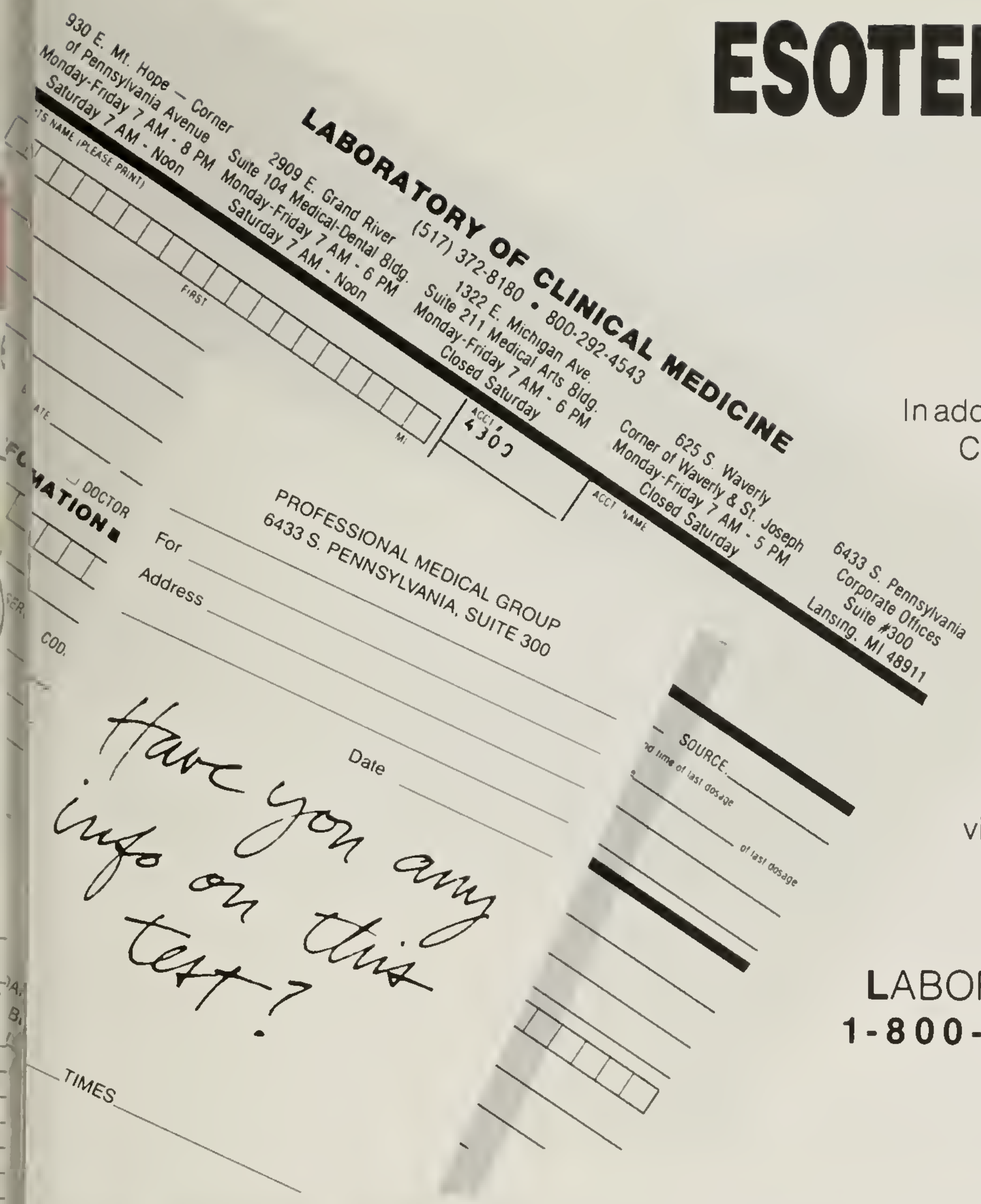

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Medical Billing Service Guides Physicians into the Future

By Peter Marabell

Remember a few years ago? The biggest headaches didn't walk through the door with patients; the biggest headaches were too often caused by trying to figure out ways to efficiently (maybe) and easily (not likely) get paid for professional services.

In the real old days — about ten years ago — sophisticated billing techniques usually included an office staff person ordering more invoices to be printed and buying another roll of stamps. Every visit by every patient had to be recorded by hand, billed by hand, and mailed by hand. Turn-around time never met the idealistic goal of two weeks.

In more recent old days, the wonderful world of in-house computers promised to be the solution to every doctor's office billing problems. Well, to some extent they were, but office computers also glitched and crashed their way into legendary tales told over a third cup of coffee very late at night.

It was clear that something was needed to allow physicians more time and energy to practice medicine on people rather than to study bookkeeping. No one denies the economic necessity of an efficient billing/payment system, but in-house computers quite simply caused as many problems as they solved. In addition they required a resident expert to ferret out trouble and keep a vigilant eye on rapidly changing developments in software.

An MSMS endorsed service

A little more than two years ago, the Michigan State Medical Society took a significant step toward solving the myriad of billing problems and exclusively endorsed a Southfield-based firm — Medical Billing Service (MBS). MBS is a computer facility dedicated to alleviating office billing problems.

According to William N. Widmyer, MBS president, the company's philosophy is aimed at allowing doctors to "direct (their) energy and take care of patients." MBS obviously hit a responsive chord since more than 600 doctors signed on in the wake of the MSMS endorsement. Since many of those installations are now almost 24 months old, a number of questions come to mind rather quickly. Have the needs of doctors, clinics, hospitals, and insurers been met? Are doctors and their office staff people confident of MBS' reliability, support and attention to detail? Have the old problems and the new problems been eliminated or reduced by MBS functions? Has MBS offered continued enhancements to its system?

Leafing through a stack of letters from MBS subscribers provides an interesting perspective on billing problems past and present. Curiously, 80 percent of the practices that signed on with MBS had their own in-house computers and the problems that went with them. M. Arthur Budden, MD, of Lansing, wrote about the inefficiency of his old in-house system, but added that he has "saved a great deal of time as well as money since going on-line with MBS." Kit Mitchell-Shotwell, of Rochester, described MBS as an "invaluable tool for controlling accounts receivable."

She also looked to the future: "We feel comfortable...that the system will never become outdated." And Sue E. Chaplin, of Flint, suggested that the latest enhancements made the system "much faster and easier."

MBS users pleased

It's clear that users are responding to MBS' ability to deal with many of the problems that surfaced as computers moved into offices. It's also obvious that MBS is continually updating its software to take advantage of new research and development. The thought that an officer person could digest all the changes in software is mindboggling. Certainly that's what Angela Phillips, of Westland, was thinking when she wrote that they never have "to fiddle with software." No more updating procedure codes, diagnosis codes, doctor codes...All we do is make a phone call and our requests are handled."

Technical support from the staff at MBS was, quite understandably, on the minds of several of those subscribers who took the time to write MBS. Each of them knew that only with knowledgeable, helpful “whiz kids” at the other end of the telephone line would MBS be better than their old in-house computers. Peggy A. Edwards-Shaw, of Southfield, described the MBS staff as “very helpful and supportive.” “Your employees,” commented Lois E. Jarvis, of Livonia, “responded as though we were part of the family.” In fact, Judy Crapo, of McLaren Women's Center in Flint, opened her letter with “Dear Support Group.” She called the MBS staff “kind, courteous, and thoughtful...you've got my vote for ‘Group of the Year,’” she concluded, “and it's only March.”

One of the most intriguing comments about the support MBS offers came from Cheryl Wilkinson, of Monroe, who no doubt speaks on behalf of so many people for whom computers are something less than user friendly: “(The staff was) very cheerful and friendly, no matter how ‘dumb’ our questions.”

In a world where development moves much more quickly than with what most people can keep up, MBS staff people are quite likely to handle many seemingly “dumb” questions. Afterall, MBS has made 13 major enhancements in the past two years. With several new ones on tap in 1989, more questions are a certainty.

Most people who wrote said that a primary reason for choosing MBS was a faster turnaround for receivables. Several people suggested that two weeks was considered quite normal for MBS. Bradley J. Clegg, MD, of Grandville, said that the system has dramatically improved his billing and cash flow. Even more to the point for new subscribers was the evaluation offered by Cheryl Wilkerson: “Your service has helped our office overcome a three-month backlog of work that we had just found impossible to catch up on.” Doctor Budden also wrote to say that “Our ability to keep an up-to-date accounting of our business is very reassuring...the ability to follow an audit trail has given us assurance of the correctness of our efforts.”

Undoubtedly, remembering the way things were a few years ago is all too likely to bring on more than a nasty headache. Human beings have an amazing capacity to forget painful memories and look to the future. Clearly, the people who wrote MBS to express their satisfaction and confidence are looking to the future secure in the knowledge that the nightmares of the old days are gone.

Franklin J. Elias, of Southfield, told MBS that is could use his letters “as a reference wherever appropriate.” That's how other letter writers felt. They wanted to share their enthusiasm. When July Fuqua, of Kalamazoo, describes the benefits of MBS, her “colleagues turn green with envy.”

It seems that William Widmyer was right. If the office billing headaches are gone, more time and energy are available for doctors and their staff people to focus on the health care of patients. So, if the idea of getting rid of your particular billing headaches sounds appealing, call Amy Fistler or John Richards at (517) 337-1351 for details. ■

Peter Marabell, a Michigan State University professor, is a freelance writer and is general manager of GPM Communications, East Lansing.

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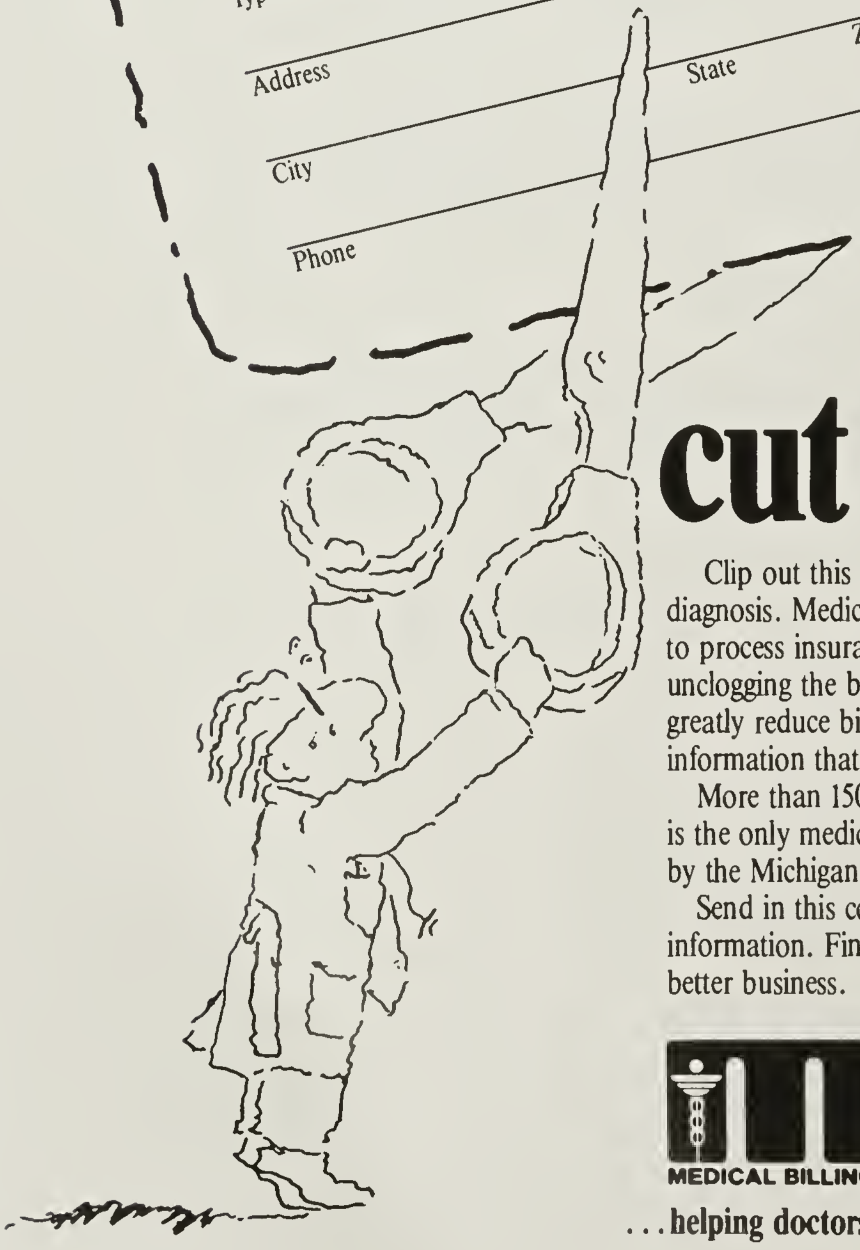

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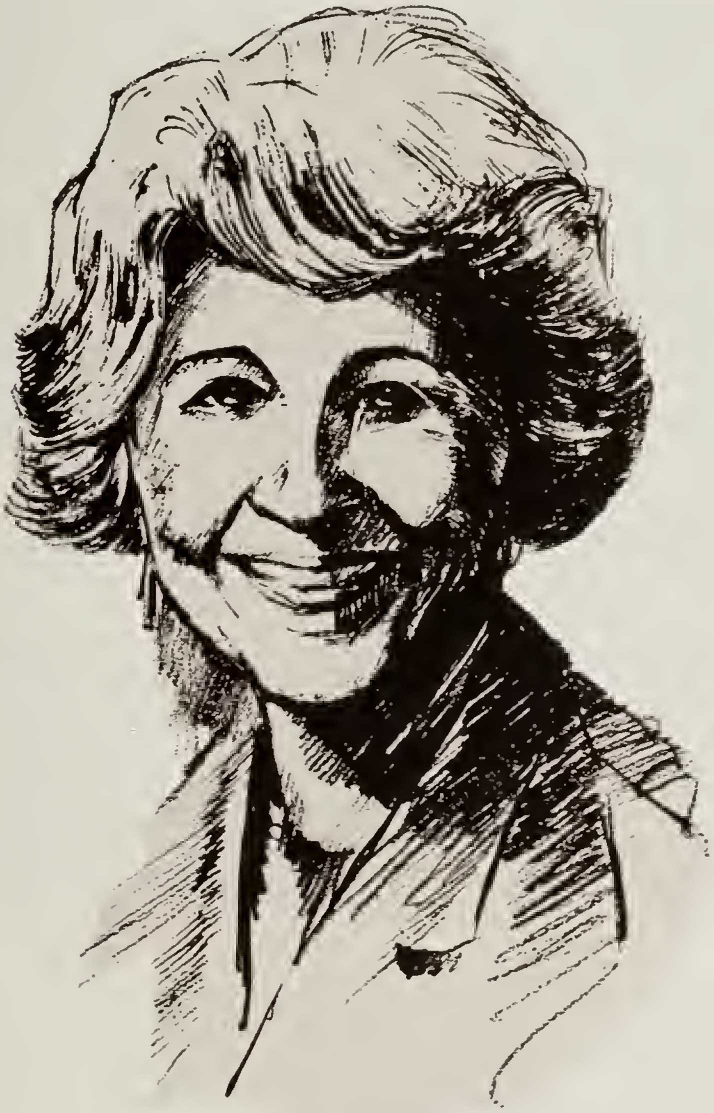
By Chad B. Munger



The Michigan State Medical Society Auxiliary, MSMS's "partner" in medicine, has a new president — Suzanne H. Pederson. A graduate of the University of Michigan, Mrs. Pederson has been an active Auxiliary member, serving in various county and state Auxiliary positions including County president, chairman of the State's long-range planning committee and vice president of the Auxiliary Board.

As a physician spouse, Mrs. Pederson is well aware of the often unstructured nature of a physician's schedule, and sees the Auxiliary as a tool to "augment knowledge of current issues in medicine that physicians are often unable to keep track of on their own."

"To be effective," says Mrs. Pederson, "Auxiliary members must take the time to educate themselves about the challenges facing their spouse's profession and the impact those challenges have on their personal and professional lives." She sees the way medicine is changing toward an emphasis on defensive medicine, and greater control by insurance companies over the type and frequency of services provided, as serious problems facing physicians.

"Promoting greater awareness and applying political pressure are ways the Auxiliary will work with physicians to change the health care climate in Michigan," states Mrs. Pederson. "I hope Auxiliary members and MSMS will help me to present a united front to respond to issues like these."

Many challenges ahead

"It's going to be a challenge to present issues to members in an effective way," says the new president, "but we have the advantage of having members, who, as a group, are seeking a lot of information."

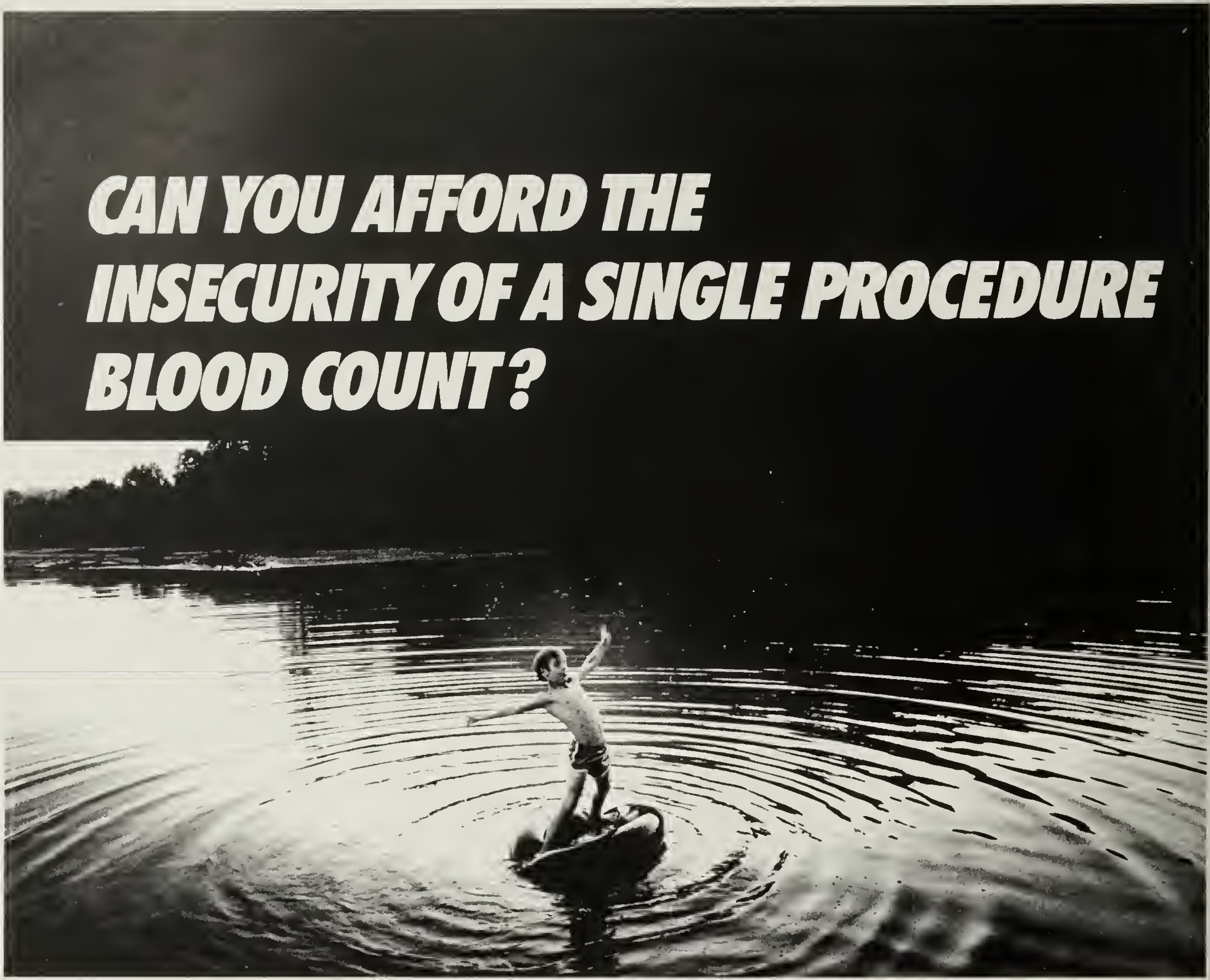
In order to reach members more often, and with more positive results, Mrs Pederson will be visiting as many county groups as possible to provide concrete information aimed at making county groups more efficient and their members better informed.

"We won't be prancing into county offices saying 'look we're state officers, aren't you impressed?' Instead, we'll be offering support to groups to help them overcome problems like membership recruitment or computerized billing." Mrs. Pederson feels this orientation towards service is especially important in light of an expected dues increase at both the state and national levels this coming year. If members are going to pay more, then they will expect more service.

"Large health-related service projects are commonly the focus of MSMSA, but these types of initiatives will not be so prominent this year," states Mrs. Pederson. "The thrust of my term will be to work more closely with MSMS and to modernize some aspects of the Auxiliary, such as computerized billing and more efficient communication. The term will be an attempt to strengthen the Auxiliary's internal structure."

As a former school board president, Mrs. Pederson brings to MSMSA a strong sense of professional demeanor and hopes to use it to improve the Auxiliary's image. "We want society and the public to realize that we are a business organization, not just a tea and krumpets or flower arranging group." ■

Chad Munger is an East Lansing-based freelance writer.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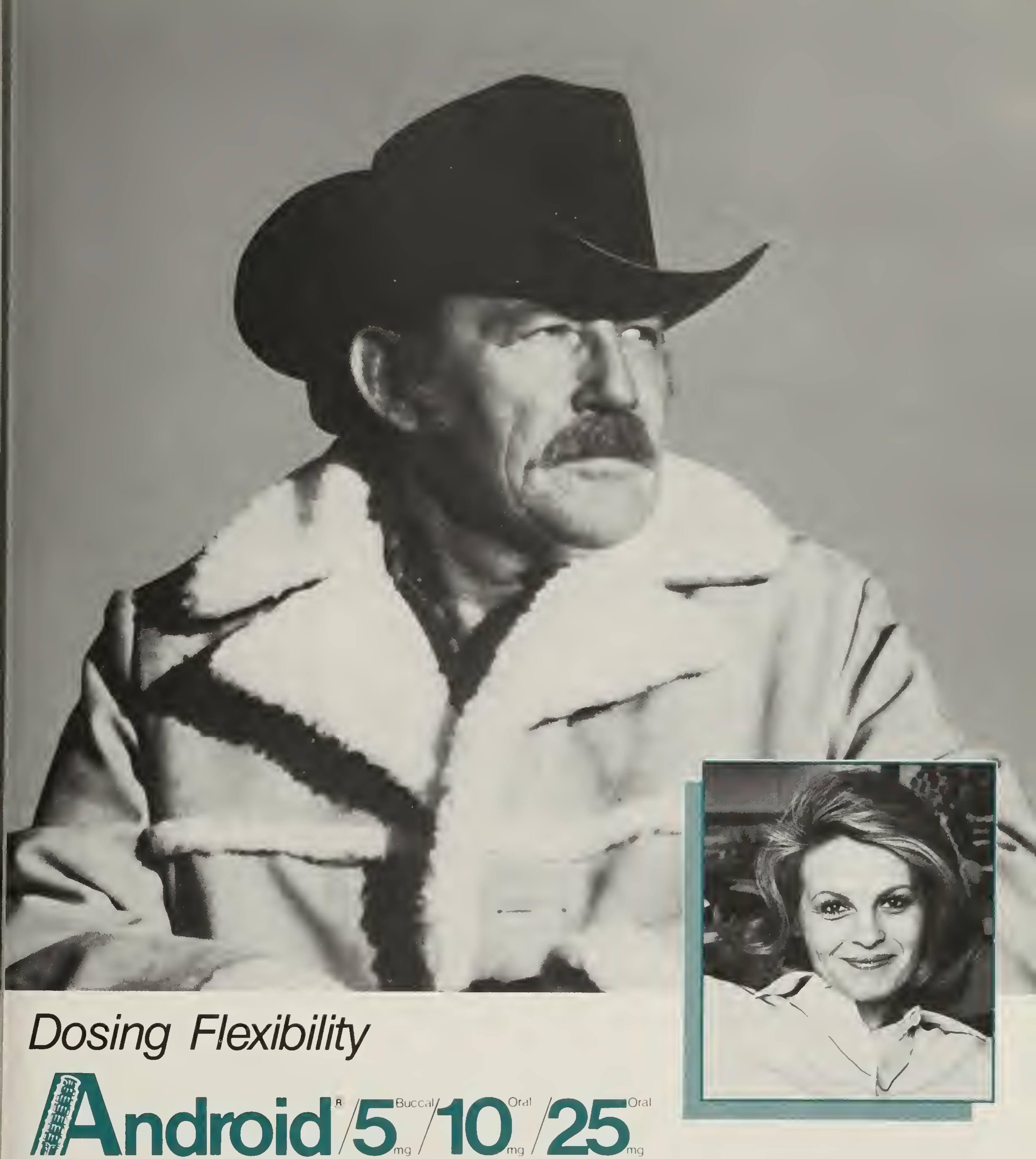

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Seven-Bill Package
Yields First Comprehensive AIDS Legislation in Michigan

By Monte D. Jahnke

A seven-bill package passed by the Michigan legislature in late December 1988, has yielded Michigan's first comprehensive AIDS legislation. The bills cover a wide range of situations relevant to the AIDS crisis and its impact on hospitals and physicians. The legislation is nevertheless clearly the product of political compromise in many respects, and it does not answer all questions related to hospitals and physicians dealing with AIDS. The new laws specifically amend the Michigan Public Health Code and Criminal Code.

Five of the bills passed were effective March 30, 1989. A sixth bill providing for the mandatory testing of prisoners was effective January 1, 1989. A bill addressing transplantation and transfusion testing, fluid testing and donor information will be effective on July 1, 1989.

Five-bill package has the most direct impact

The five-bill package (effective March 30) has the most direct impact on practicing physicians. These bills create new duties for physicians with respect to certain types of patients. Physicians testing for HIV infection pursuant to these laws are afforded immunity from suit in many circumstances and are given fairly wide discretion concerning the dissemination of testing information.

Several common themes pervade the entire seven-bill package. First, only a very narrow class of patients can be tested without consent. Testing is mandatory for convicts entering the prison system, as it is for convicted prostitutes. A local health department has discretion to test those arrested and charged for prostitution, pre-conviction. Similarly, upon conviction, rapists and intravenous users of controlled substances, and certain other sexual crime offenders, can be tested without consent.

Informed consent a major feature of the seven bills

A second major feature of the package is informed consent. The bills designate mandatory testing situations where, although physicians must provide testing, patient consent will also be required before testing can occur. In most instances counseling "appropriate to the test subject" must be provided by a physician ordering an HIV test.

These classes of persons include blood or organ donors, subject to some narrow exceptions. Where tests cannot be performed on blood or donated organs due to emergency or other exigent circumstances, potential recipients must be so informed and must agree to give consent in order to receive the blood or organ. If recipients are not available or conscious to provide consent, a hierarchy of persons (spouse, adult son or daughter, etc.) is established for consent purposes by the statute. Similar provisions are also made for minor patients.

Physicians must test pregnant women at the time of their initial pregnancy examination. Test specimens must be sent to a clinical laboratory approved by the Michigan Department of Public Health (MDPH). A test need not occur, however, if, in the physician's opinion, the tests are medically inadvisable or, more importantly, if the patient will not consent.

Hospitals need not require consent if, at admission, the patient is informed in writing that a test will be performed should a health care professional or employee sustain a wound and be exposed to the blood or body fluid of the patient. This does not permit mandatory testing at admission without consent; it is only an after-the-fact exception to the consent rule. One of the failings of the seven-bill package is that it does not specifically address the dilemma presented by a comatose trauma patient. Testing such persons for HIV without their consent on a state-mandated form will not give the hospital or physician immunity and will likely be subject to existing tort law standards on emergency treatment which may or may not imply informed consent under the circumstances.

Persons collecting self-replicating body fluids, such as breast milk, must test potential donors. The donor's fluids cannot be accepted absent consent to testing or if the donor tests positively. This does not apply to blood or sperm donors. Blood donors are covered as described above. Sperm received must be frozen for six months, and sperm donated by anyone who has tested positive may never be used for artificial insemination purposes.

Where consent is required, physicians may achieve immunity from prosecution, private lawsuit and licensure proceedings by obtaining the consent in writing. There is one important proviso: consent must be obtained on a designated form now under development by MDPH. The form is to be available free of charge to physicians, and must contain certain information designated by the statute. Any physician conducting HIV testing and not subject to one of the narrow exceptions from informed consent requirements should use the designated form and can obtain it for free from MDPH, the Michigan Board of Medicine or Board of Osteopathy. Forms will be printed in English and Spanish.

A minor may give binding informed consent using the form without a parent or guardian's authorization, and physicians may or may not inform parents or guardians of the test results. This is completely up to the physician's discretion, again provided that appropriate informed consent has been obtained.

Physicians must report positive tests to certain agencies under most circum stances. The MDPH must be notified within seven days when a physician receives a positive result. A designated MDPH reporting form must be used. Local health departments must be notified of all relevant data including name, address and telephone number of the subject tested. Exceptions to this and to the full MDPH reporting requirement arise if a physician testing in a private office or HMO context receives a request from the patient that his or her name, address and telephone number should not be included. Physicians must comply with such requests except where they deem partner notification necessary.

Confidentiality a general theme throughout package

A final general theme throughout the seven-bill package is confidentiality. Except for limited purposes stated under the mandatory reporting provisions, all reports of tests are regarded as confidential and are not subject to release by state agencies under Michigan's Freedom of Information Act. Local health departments may only retain such records for up to 90 days, subject to local rule modifications expanding or limiting this time.

A physician may disclose test results directly to partners, rather than going through the local health department as discussed above, if the physician determines that information should be given to the partner to "prevent a reasonably foreseeable risk or further transmission." Physicians may also report to health departments or to other health care providers positive test results in order to protect the health of an individual or to prevent further transmission, or to aid diagnosis. Importantly, there is no affirmative duty placed upon physicians by the new laws to disclose information to an individual who is known to be a contact partner of the HIV-infected individual.

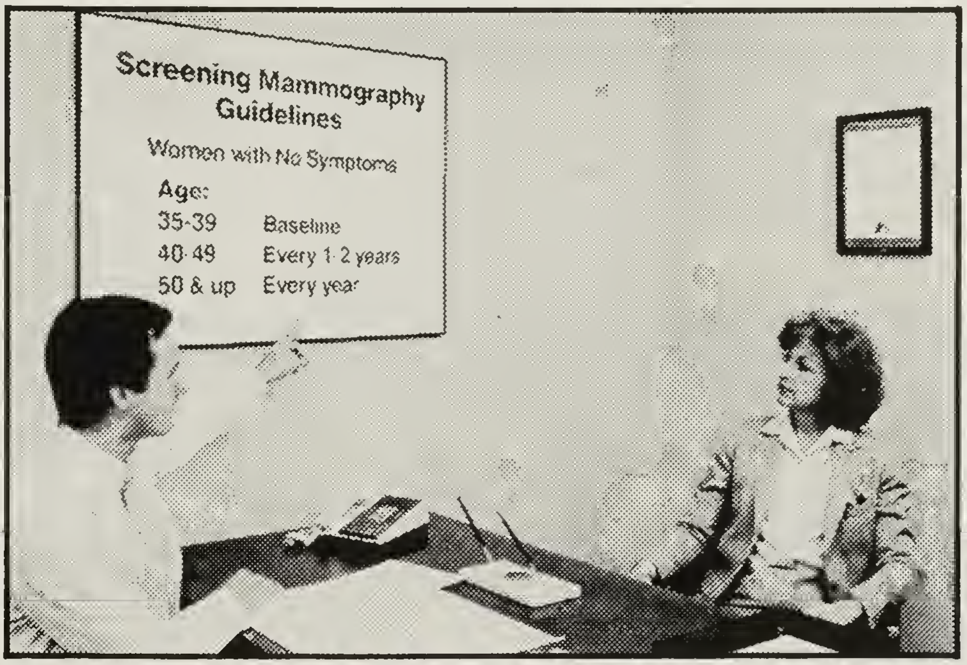
Marriage applicants have presented special problems of late. Physicians or local health officers are under a duty to counsel individuals applying for marriage licenses. The scope of this counseling is to cover the transmission and prevention of venereal disease and HIV infection. Physicians need not assume that everyone who demands counseling from them is entitled to it. Only those persons accepted as patients of the physician have a right to demand the counseling. Alternatively, public health officials may be in a position to provide such counseling. The statute does not specifically prohibit charging for such counseling. Fees charged should be reasonable in nature, however.

HIV testing must be offered to marriage license applicants. If the test is positive, physicians must immediately inform both applicants of the result and must counsel them regarding the modes of HIV transmission, the potential for transmission to a fetus, and protective measures.

Other than mandatory reporting, any person who discloses that a marriage applicant has taken a test for VD or HIV infection or discloses the results of such test, is guilty of a misdemeanor. Physicians or local health officers must provide a certificate to the applicant stating that they have been counseled and offered testing. These are required to be presented by the applicant to county clerks issuing marriage licenses.

In conclusion, it is important for physicians to determine the testing context facing them in each patient situation. Different rules apply to different settings. It is important to re-emphasize that legal immunity which may be asserted by physicians only applies when physicians obtain informed consent using the State Department of Public Health designated form. Physicians should proceed cautiously in HIV testing situations, and should seek the advice of knowledgeable health care administrators or counsel in unclear situations. ■

The author is an attorney at Kerr, Russell and Weber, Detroit.



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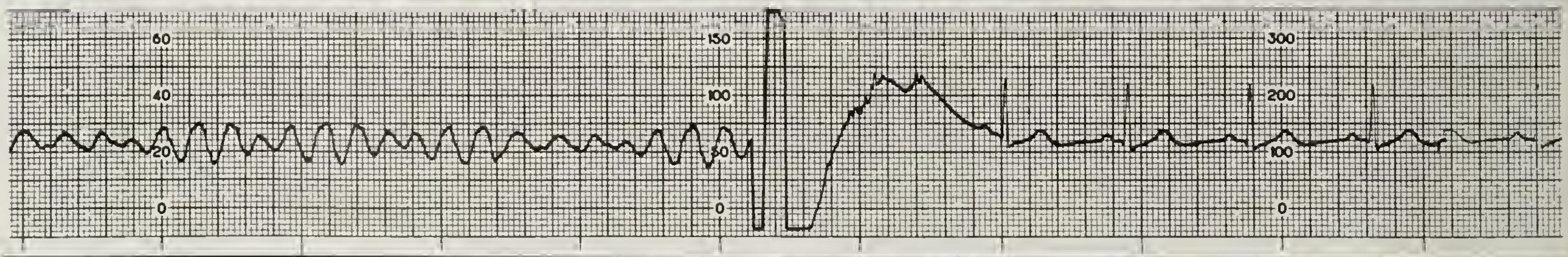

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MDPH Sets Emergency Rules For Management,

HANDLING OF MEDICAL WASTES

On Tuesday, April 25, 1989, Governor James Blanchard announced Michigan would not exercise the option to participate in Federal regulations for the handling of infectious medical wastes and for tracking the disposal of medical wastes. As an alternative, the Governor directed the Michigan Department of Public Health to file emergency rules for the management and handling of medical wastes. Both the Governor and the Legislature feel it is critical to have medical waste regulations in place before the summer recreational season begins.

Physician offices, clinical laboratories, hospitals, and other health facilities must comply with the rules by having a waste management plan on file by *June 12, 1989*. In the meantime, legislative deliberations on medical waste continue, with many proposals for more stringent regulation of medical waste under consideration. MSMS will continue to inform its members of progress on these discussions through *Michigan Medicine* and *Medigram*.

To assist members in complying with the new regulations, the complete text of the rules follows.

Definitions

Rule 1: (1) As used in these rules:

- (a) “Autoclave” means sterilize using superheated steam under pressure.
- (b) “Code” means Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws.
- (c) “Decontamination” means rendering infectious medical waste safe for routine handling as solid waste.
- (d) “Department” means the Michigan Department of Public Health.
- (e) “Facility” means a site under a generator’s ownership or control where infectious waste is generated, stored, decontaminated or incinerated.
- (f) “Generator” means a person whose business or professional activities produce infectious medical waste.
- (g) “Household” means a single detached dwelling unit or a single unit of a multiple dwelling.
- (h) “Infectious agent” means an organism, such as a virus or bacterium, that is capable of being communicated by invasion and multiplication in body tissues and capable of causing disease or adverse health impacts in humans.
- (i) “Infectious medical waste” means any of the following when not generated from a household or from a farm operation or agricultural business:
    - (I) Cultures and stocks of infectious agents and associated biologicals, including laboratory waste, biological production wastes, discarded live and attenuated vaccines, culture dishes, and related devices.
    - (II) Liquid human and animal waste, including blood and blood products and body fluids, but not including urine or materials stained with blood or body fluids.
    - (III) Pathological waste.
    - (IV) Sharps.
    - (V) Contaminated wastes from animals that have been exposed to agents infectious to humans, these being primarily research animals.
- (j) “Laboratory” means a research, analytical, or clinical facility that performs health care-related analysis or service. It includes medical, pathological, pharmaceutical, and other research, commercial, or industrial laboratories.
- (k) “Pathological waste” means human tissues, organs, products of conception, body parts other than teeth, and body fluids removed by trauma or is surgery, autopsy, or other medical procedure and not fixed in formaldehyde.
- (l) “Person” has the same meaning as defined in section 1106 of the code, but includes “local health department” as that term is defined in section 1105 (2) of the code.
- (m) “Sharps” means needles, syringes, scalpels, intravenous tubing with needles attached, and any other medical or laboratory instruments or glassware that might cause punctures or cuts, but does not include needles used by an individual who is not an employee of a home health agency to inject insulin or other physician-prescribed medications in a residence other than a health care facility as defined in section 20106 of the code.

Infectious medical waste management

Rule 2: (1) A generator shall package, contain and locate infectious medical waste in a manner that prevents and protects the waste from release at the facility or at any time before ultimate disposal.

(2) A generator shall separate the categories of infectious medical waste at the point of origin into appropriate, properly labeled containers. The generator shall clearly label a container used to collect, transport, or store infectious medical waste with a biohazard symbol or with the words “infectious medical waste” or “pathological waste” written in letters at least one inch high. The generator shall not compact or mix infectious medical waste with other waste materials before decontamination or incineration and disposal. If a generator mixes decontaminated waste with other solid waste that is not infectious waste, the generator shall provide a clear label on the container used for transport or other notice to subsequent handlers of the waste that the waste includes decontaminated infectious medical waste.

(3) If infectious medical waste is stored in a generating facility, a generator shall store it is such manner that putrefaction will not occur and infectious agents will not come in contact with the air or individuals.

(4) If a generator stores infectious medical waste outside of a generating facility, the waste shall be stored in a secured area or be locked in rigid containers that weigh more than 500 pounds and prevent access to the container by vermin or by unauthorized individuals who are not responsible for disposal.

(5) From the options available for decontaminating or disposing of a type or item of infectious medical waste, a generator shall select a method appropriate to the level of risk the type or item of infectious medical waste poses for causing serious or potentially lethal disease.

(6) Cultures and stocks of infectious material shall be stored in closed, puncture-proof containers, decontaminated by autoclaving or incineration, and disposed of in a sanitary landfill.

(7) Human blood and blood products and body fluids shall be disposed of by any of the following methods:

- (a) Flushing down a sanitary sewer.
- (b) Decontaminating by autoclaving or incineration.
- (c) Solidifying.
- (d) Transferring to a sanitary landfill.

(8) Pathological waste shall be disposed of by any of the following methods:

- (a) Incineration or cremation.
- (b) Grinding and flushing into a sanitary sewer.
- (c) Burial in a cemetery, if transported in leak-proof containers of sufficient integrity to prevent rupture.
- (d) Grinding until rendered unrecognizable, stored in closed, puncture-proof, properly labeled containers, and disposed of in a sanitary landfill.

(9) Sharps shall be disposed of by one of the following methods:

- (a) Placement at the facility in rigid, puncture-proof containers that are appropriately labeled and transported to a sanitary landfill in a manner that retains the integrity of the container.

(b) Incineration or decontamination and grinding that renders the objects unrecognizable. Ground sharps shall be placed in a sealed, rupture-proof container and transported to a sanitary landfill.

(c) Another process approved by the department.

(10) Animal waste contaminated with organisms infectious to humans shall be disposed of by incineration or by burial in a sanitary landfill in properly labeled, double containers that are leak-proof and puncture-resistant and are tightly sealed to prevent escape of fluids or material. Contaminated animal organs disposed of separately shall be rendered unrecognizable.

Management plans

Rule 3: (1) A generator shall prepare a management plan for the handling of all infectious medical waste generated, stored, decontaminated, or incinerated at each facility of a generator or transported from the facility for handling by another facility, for storage, decontamination, incineration, or for disposal in a sanitary landfill, cemetery or other disposal site. A professional corporation may identify and prepare a common plan for all generators at a facility who belong to the corporation.

(2) The management plan shall describe each of the following, to the extent the information is applicable to the facility:

(a) The types of infectious medical waste handled.
(b) The segregation, packaging, labeling, and collection procedures used.
(c) The use and methods of on-site or off-site storage.
(d) The use and methods of on-site or off-site decontamination.
(e) The use of on-site or off-site incineration.
(f) The use of clearly identified solid waste haulers.
(g) The use of clearly identified sanitary landfills, cemeteries and other clearly identified disposal sites.
(h) The measures to minimize exposure of the facility's employees to infectious agents throughout the process of handling and disposing of the infectious medical waste, including, where applicable, the use of protocols, procedures and training, personal protective devices or systems, and prevention or control of aerosols.
(i) The name of the individual responsible for the management of the infectious medical waste.

(3) The management plan shall comply with the requirements of Rule 2.

(4) The management plan shall be prepared and available for inspection at the facility no later than 45 days after the effective date of these rules. The generator shall update the plan each time there is a change in any of the following:

(a) A person or site named in the plan.
(b) The types of infectious medical waste handled or the methods of handling at the facility. The current plan shall be maintained and available for inspection at the facility.

(5) The generator shall comply with its management plan.

Plan review

Rule 4: (1) The department may audit a management plan onsite at the facility or request a copy of the management plan in use by the facility. Upon review of the plan, the department may require a generator to modify a management plan at any time the department determines the plan is not adequate to protect the public health or is inconsistent with these rules or state or federal law. The generator shall modify the plan within 10 days of the notice from the department.

(2) The department may issue a warning to a generator who fails to modify a plan with the 10-day period.

(3) The department shall establish procedures for random audits of the following:

(a) Generators' compliance with the requirements to prepare plans and keep them available for inspection.
(b) The content of the plans.

Compliance, investigations, enforcement, penalties

Rule 5: (1) A person subject to these rules shall continuously comply with these rules and the provisions of a plan the person has prepared pursuant to these rules.

(2) The department or a local health department may monitor compliance with these rules and may investigate allegations of noncompliance with these rules. Pursuant to section 2241 or 2446 of the code, the department may inspect, investigate, or authorize an inspection or investigation to be made of any matter, thing, premise, place, person, record, vehicle, incident or event to determine compliance with these rules.

(3) The department or a local health department may apply for an inspection or investigation warrant pursuant to section 2241 of the code to carry out the provisions of this rule.

(4) A person may notify the department or a local health department of a violation of these rules that the person believes exists. The department or a local health department may investigate the complaint pursuant to the provisions of this rule. The department shall, in conjunction with the department of licensing and regulation and the department of natural resources develop procedures for the receipt, review, and investigation of allegations of noncompliance with these rules.

(5) If the department or local health department determines that a person is in violation of these rules, the department or local health department may do one or more of the following:

(a) Issue an order to avoid, correct, or remove the violation, pursuant to section 2251, 2451, or 2455 or the code.
(b) Maintain, or request the attorney general or a local prosecuting attorney or civil counsel to maintain, injunctive action to restrain, prevent or correct the violation of these rules, pursuant to sections 2255 and 2465 of the code.
(c) Take another enforcement action authorized by the code or law.
(d) Publicize or report the violation or enforcement action, or both, to a person.
(e) Issue a citation and assess a civil fine in accordance with sections 2262 and 2263 of the code as follows:
    (I) Failure to prepare or update a plan as required by Rule 3 - $500.
    (II) Violation of any provision of Rule 2 - $1,000.00 per day for each violation or for each day the violation continues.
    (III) Failure to modify the management plan after a warning under Rule 4 – $1,000 per day for each violation or for each day the violation continues.
    (IV) Failure to comply with the management plan under Rule 3 - $1,000.00 per day for each violation for each day the violation continues.

(6) In addition to other remedies with respect to generators, if the generator is a health facility or agency licensed under article 17 of the code, the department may take any action authorized under article 17 for a violation of that article or a rule promulgated under that article, including, but not limited to, the issuance of a compliance order under section 20162 (5) of the code; the denial, limitation, suspension, or revocation of a license pursuant to section 20165 of the code; or the issuance of an emergency order under section 20168.

(7) The penalties prescribed by these rules are cumulative and not exclusive. The department, a local health department, or another person shall not be limited to the remedies listed in these rules, and the use of one remedy shall not bar the use of another remedy authorized by law.

(8) Compliance with these rules does not exempt a person from compliance with section 3a of Act No. 106 of the Public Acts of 1963, as amended, being S752.903a of the Michigan Compiled Laws, which establishes penalties for littering public and private property and waters with infectious waste, pathological waste, and sharps as defined in that act.

(9) Nothing in these rules shall be construed to limit the department's authority to take action against a person or household that is not subject to these rules for generation or handling of infectious medical waste under section 2251 or section 2455 of the code.

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DEATHS

William E. Clark, MD
Mason

Doctor Clark, a retired neuropsychiatrist, died February 25, 1989, at the age of 81. He graduated from University of Michigan in 1936 with degrees in pharmacy and medicine. Doctor Clark served during World War II as a Major in the 6th Armored Division and received many citations for meritorious service. He was a member of the Ingham County Medical Society, Michigan State Medical Society, the American Medical Society, and the American Psychiatric Society.

Robert W. Claytor, MD
Grand Rapids

Doctor Claytor, a retired family physician, died February 27, 1989. He was 91. Originally from Virginia, he began his medical training at Northwestern University and then moved to Nashville, Tennessee, to complete his training at Meharry Medical College. After graduating, he became the first black physician on staff at St. Mary's Hospital. Doctor Claytor received the Michigan Family Physician of the Year Award in 1976 and was honored in 1984 for 50 years of family practice.

Harold H. Lampman, MD
Detroit

Doctor Lampman, an obstetrician and gynecologist, died February 17, 1989, at the age of 92. Doctor Lampman was a graduate of Alma College and the Rush Medical College at the University of Chicago. He practiced at Grace Hospital and Hutzel Hospital. He was a former president of the Wayne County Medical Society and a member of the American Medical Association. He was also active in the American College of Surgeons and the Central Association of Obstetricians and Gynecologists.

Donald H. McCandliss, MD
Pontiac

Doctor McCandliss, an internist, died February 15, 1989. He was 63. After graduating from the University of Michigan School of Medicine in 1953, he began his internship at Pontiac General Hospital. He then became a staff member at Pontiac General Hospital where he practiced for 30 years. Doctor McCandliss was a member of the American Medical Association, the Michigan State Medical Society, and the Oakland County Medical Society.

Robert A. Peterson, MD
Gaylord

Doctor Peterson, a pathologist and general practitioner, died February 11, 1989, at the age of 64. He was a graduate of Northwestern University and the Wayne State University School of Medicine. He established a laboratory in Gaylord in 1975 and resided there as a pathologist and as the Otsego County Medical Examiner until his death. He was a member of the American Medical Association, the Michigan State Medical Society, the College of American Pathologists, and the American Society of Clinical Pathologists.

J. Walton Pichette, MD
Dearborn

Doctor Pichette, a retired gynecologist, died March 3, 1989. He was 73. Originally from Quebec, he came to Detroit to receive his medical training at Wayne State University Medical School. He graduated in 1942 and then began a private practice in Dearborn until his retirement. He was a member of the American Board of Obstetrics and Gynecology, the American College of Obstetrics and Gynecology, the Michigan Society of Obstetrics and Gynecology, and the Wayne County Medical Society.

Praveen Sachdev, MD
Brooklyn

Doctor Sachdev, a radiologist at Foote Hospital for 10 years, died March 11, 1989, in Seattle, Washington. She was 45. Her death resulted from complications following a bone marrow transplant. Doctor Sachdev graduated from Amritsar Medical College, Punjab, India, and completed her residency at Sinai Hospital, Detroit. It was under her guidance that the ultrasound section at Foote Hospital became known as one of the best units in the state. An instructor at the University of Michigan, she was a member of the American College of Radiology, the Radiological Society of North America, and the American Institute of Ultrasound in Medicine.

Raymond T. Stefani, MD
Livonia

Doctor Stefani, a retired Detroit physician, died February 23, 1989, in Mary Crest Manor, Livonia. He was 82. Doctor Stefani was a graduate of the University of Detroit and the St. Louis University Medical School. He had practiced in Detroit for more than 50 years. He was a physician for the Detroit Fire Department and also the Veterans Administration. Doctor Stefani was a member of the American Medical Association, the Elks, and the Veterans of Foreign Wars.

Donald Waterman, MD
Grand Rapids

Doctor Waterman, a pediatrician, died February 15, 1989. He graduated from Harvard University in 1939. Doctor Waterman was a professor of pediatric and human development in the Michigan State College of Human Medicine and also maintained an office at the headquarters for the Grand Rapids Area Medical Education Center at Saint Mary's Hospital. He established a pediatric practice in Grand Rapids in 1951 and began the Genetics Birth Defects Clinic in 1958. The clinic is situated in Blodgett and serves more than 1,000 patients per year in West Michigan.

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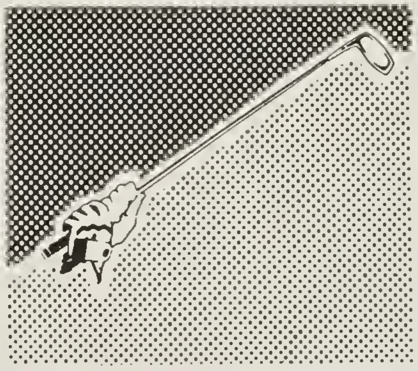

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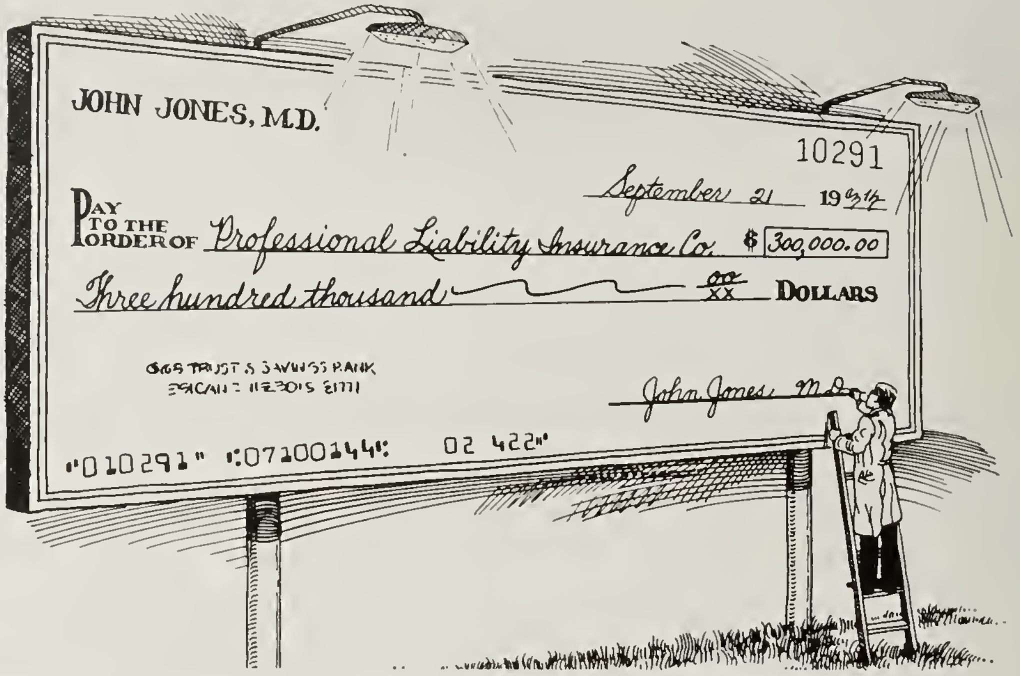
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"The Nilson Report" (a credit card executive advisory service) recommended the original "How to Find Missing Persons" Manual to every business in issue No. 164, of July 1981.

The Manual is authored by Don Elliott. His background includes over 25 years of investigative experience as a Naval Intelligence Officer, Retail Credit Administrator, and Owner of Collection Agencies.

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

Reference:

1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

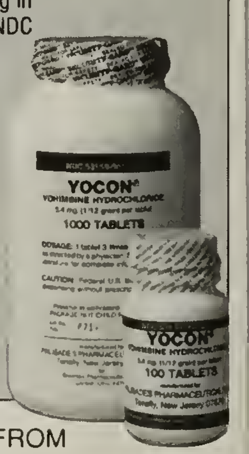
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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1989 MSMS TOP ISSUES

MSMS has a plan of action for 1989 emphasizing its top issues. The Board has approved the plan, as introduced by MSMS President Fred W. Bryant, MD. "We are gearing for a high-energy year," said Doctor Bryant. Though professional liability leads the list, the other items are of key importance, also. They are:

1. Professional Liability:	MSMS is lobbying for protection of pension and profit-sharing plans in the event of bankruptcy proceedings. Speaker-elect Lewis Dodak has promised that pension protection legislation will be a priority in the 1989 session. MSMS also is exploring non-tort alternatives such as: — An at-fault system which would pay compensible claims similar to workers' compensation payments. MSMS is joined in this effort by the Michigan Hospital Association. — A program similar to the Swedish patient compensation, risk management and physician discipline systems. — Either mandatory arbitration or reduced health insurance premiums for physicians using the Michigan arbitration system. — A "bad baby" fund similar to the recently-enacted Virginia plan which helps compensate for birth-related injuries regardless of cause. MSMS is reviewing the plan as part of a demonstration project for the Health Policy Agenda for the American People. — MSMS will continue to seek tort reform, pressing for removal of the exceptions to the cap on non-economic damages, further improvement in the statute of limitations, stricter qualifications for expert witnesses, evaluation of the modification of the joint and several rule, and countersuit legislation.
2. Integrated Licensure:	MSMS will lead in developing a new physician discipline structure similar to that of the State Bar.
3. Risk Management:	MSMS will inform Michigan physicians of how to minimize risks of lawsuits and how to take advantage of premium reductions for attending risk management seminars.
4. AIDS:	MSMS and the State Bar are developing a series of policy statements to protect physicians in management of AIDS patients. The policies will go to the legislature in early January. MSMS also leads in AIDS provider education efforts through a Michigan Department of Public Health grant.
5. Quality Health Care:	MSMS will continue to emphasize quality health care in the face of cost containment, in dealings with the new Governor's Task Force on Managing Health Care Costs, and in a joint effort with the Michigan Health Data Corporation and Michigan Hospital Association to develop a quality institute.
6. Physician Education:	MSMS will continue to provide continuing medical education, updates on preserving quality of care and on improving practice productivity.
7. Hospital Medical Staffs:	MSMS leaders will work to address nearly 20 hospital medical staffs at their general meetings in 1989. This will continue the "Physicians' Issue Presentations" initiated in 1988 which complement activities of the MSMS Hospital Medical Staff Section.
8. Third Party Payers:	MSMS will continue its advocacy efforts on behalf of Michigan physicians with Blue Cross Blue Shield of Michigan, Medicaid, Medicare, and MPRO.
9. RBRVS:	MSMS will serve as convenor for discussions with the 34 recognized Michigan specialty societies, to discuss the Harvard Resource-Based Relative Value Scale (RBRVS). MSMS also will propose four informational forums with RBRVS experts.
10. Physician Recovery Network:	MSMS is seeking legislation which would create a joint MSMS/Board of Medicine program to divert physicians into treatment and grant them immunity while working in the program. MSMS is actively pursuing alternative funding for the Network sponsored by MSMS and MAOPS.
11. Elder Care:	MSMS will establish liaison with the Michigan Office of Services to the Aging and the Michigan Chapter, AARP.
12. Media & Public Relations:	MSMS will increase efforts to serve as a reliable source of information to the public and media.
13. Non-dues Income:	MSMS will continue to improve its financial soundness by enhancing non-dues income. Hagadorn, Inc., a joint venture with MPMLC, is expected to provide a longterm real estate investment to enhance revenues. Physician Service Group, Inc., and the Peer Review Organization of Michigan, wholly-owned subsidiaries of MSMS, continue to increase non-dues revenues.
14. As Always:	MSMS will continue to emphasize county society activities, member communications, recruitment, benefits and political activity. As always, the goal of all MSMS activities is to ensure the availability of, and access to, quality medical care for the people of Michigan.

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And you have the talents and skills to justify her trust. Don't let alcohol or drugs jeopardize this beautiful relationship. The Physicians Recovery Network can help.

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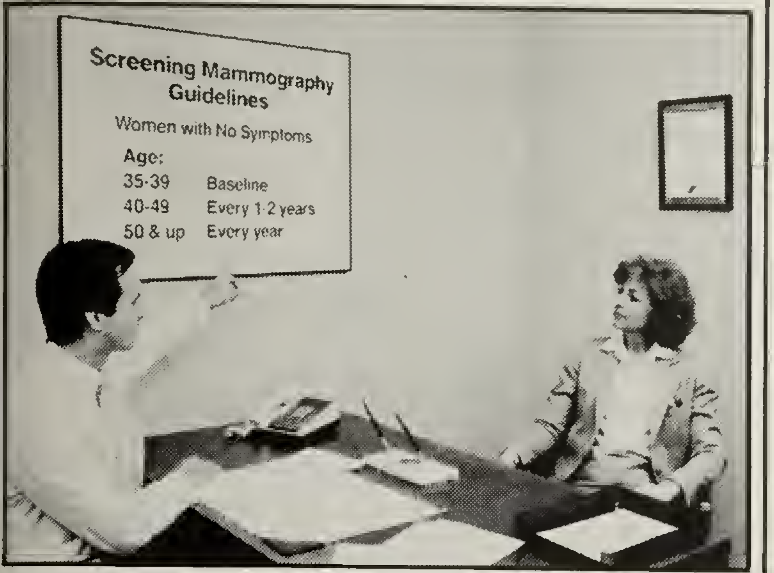

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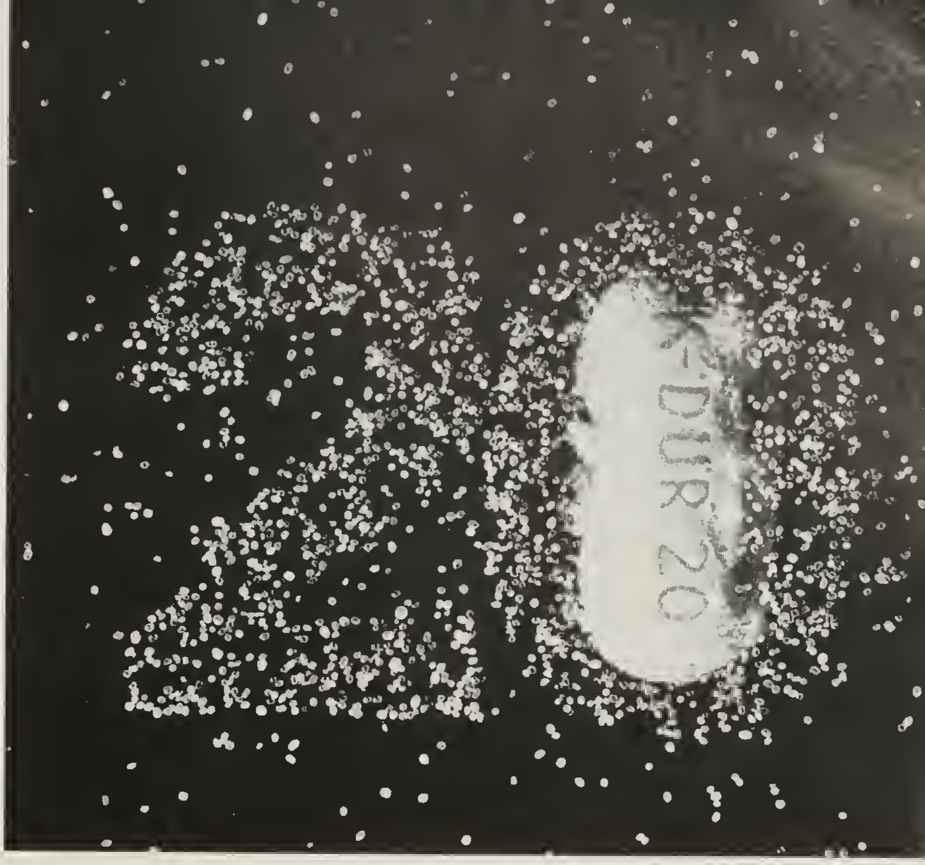

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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1 For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2 For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e g , spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g , spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2 Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3 Correction of acidosis, if present, with intravenous sodium bicarbonate.
4 Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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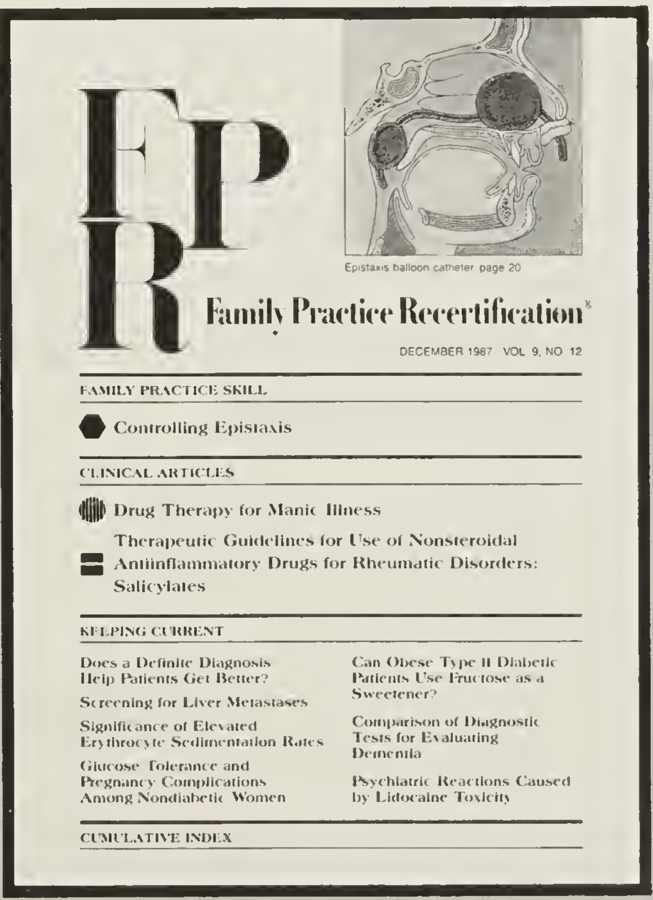

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Epistaxis balloon catheter page 20

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LENDER

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Paul M. Byrnes, MD — OBG
755 High Street
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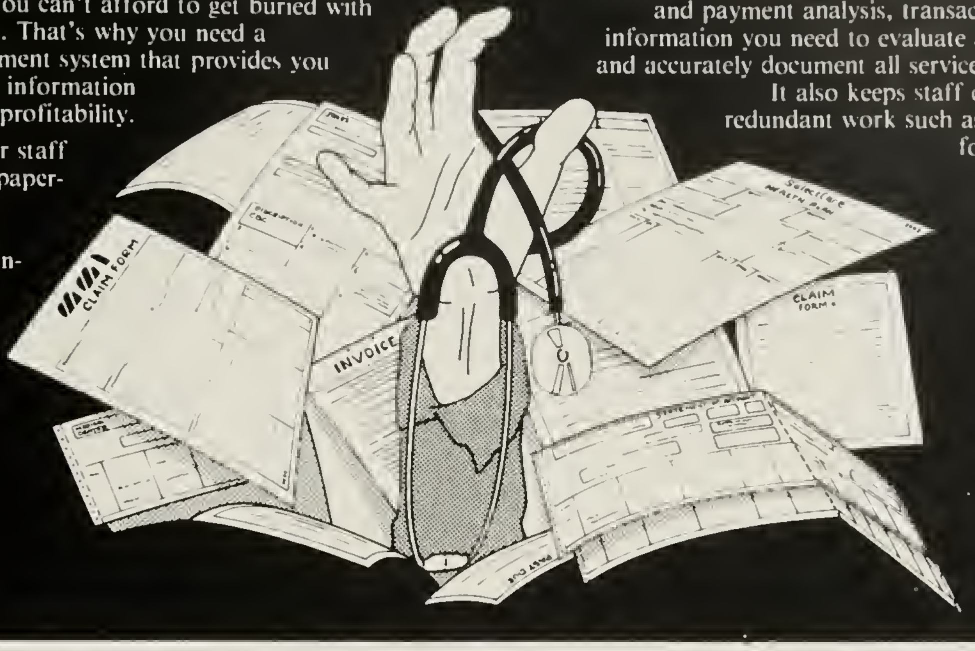

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MEETINGS

MSMS Meetings

June

1-2, MSMS Committee on Maternal and Perinatal Health, Gull Lake Conference, Hickory Corners, Michigan, Contact: Katie Brewbaker, MSMS Chief, Support Services, (517) 337-1351.

July

13-15, MSMS Board of Directors Mid-Summer Meeting, Shanty Creek, Bellaire, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

September

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

26, MSMS Public Affairs/Leadership Conference, Radisson Hotel, Lansing, Michigan, Contact: Mary Anne Ford, MSMS Chief, State Government Affairs, (517) 337-1351.

28, 1989 CME Conference, Hilton Inn, Lansing, Michigan, Contact: Katie Brewbaker, MSMS Chief, Support Services, (517) 337-1351.

AMA Meetings

June

18-22, AMA House of Delegates Annual Meeting, Chicago Hilton, Chicago, Illinois, Contact: AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-5000.

October

2-3, Eighth Annual AMA Science Reporters Conference, Marriott Medical Center Hotel, Houston, Texas, Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-4417.

Michigan Specialty Society Meetings

June

1-2, Michigan Occupational Medical Association Spring Scientific Seminar, Bay Valley Hotel and Resort, Bay City, Contact: John Bernick, MD, 20900 West Road, Woodhaven, MI 48183 (313) 671-7251.

3, Michigan Society of Pathologists Spring Meeting, Amway Grand Plaza, Grand Rapids, Contact: Viola M. Heins, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351.

22-24, Michigan Orthopaedic Society Annual Meeting, Boyne Highlands, Contact: Arthur Manoli, II, MD, Orthopaedic Surgery, Hutzel Hospital, 4707 St. Antoine, Detroit, MI 48201 (313) 745-6955.

22-25, Michigan Otolaryngologic Society, Annual Statewide Meeting, Contact: Karen Turner, Wayne County Medical Society, 1010 Antietam Road, Detroit, MI 48207 (313) 567-1640.

July

10-12, Sixteenth Michigan Emergency Medicine Assembly/Annual Meeting, Grand Hotel, Mackinac Island, Contact: Kathryn Hopkins, 500 Lansing Road, Charlotte, MI 48813 (517) 645-8050.

31-8/2, Michigan Academy of Family Physicians, 43rd Annual Scientific Assembly, Grand Traverse Resort, Acme, Contact: Julie Nelson, 109 East Oakland, Lansing, MI 48906 (517) 482-7410.

November

11, Michigan Psychoanalytic Society, Annual Symposium on "How Therapy Works: A Contemporary Perspective," Hyatt Regency Hotel, Dearborn, Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076 (313) 557-8633.

National Specialty Society Meetings

June

11-15, American Society of Colon and Rectal Surgeons, Annual Meeting, Sheraton Centre, Toronto, Ontario, Canada, Contact: American Society of Colon and Rectal Surgeons, 615 Griswold, Suite 1717, Detroit, MI 48226 (313) 961-7880.

12-15, American Orthopedic Association, Annual Scientific Meeting, The Broadmoor, Colorado Springs, CO, Contact: American Orthopaedic Association, 222 S. Prospect Avenue, Park Ridge, IL 60068 (312) 823-7186.

13-16, The Society of Nuclear Medicine, Annual Scientific Meeting, St. Louis, MO, Contact: The Society of Nuclear Medicine, 136 Madison Avenue, New York, NY 10016 (212) 889-0717.

September

10-13, Society of Thoracic Surgeons, Annual Meeting, Convention Center, Baltimore, MD, Contact: Society of Thoracic Surgeons, 111 E. Wacker Drive, Suite 600, Chicago, IL 60601 (312) 644-6610.

10-14, American College of Radiology, Annual Meeting, Westin Hotel, Seattle, WA, Contact: American College of Radiology, 1891 Preston White Drive, Reston, VA 22091 (703) 648-8900.

11-14, American College of Emergency Physicians, Annual Scientific Meeting, Grand Hyatt Washington, Washington, DC, Contact: American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911 (214) 550-0911.

16-21, American Academy of Family Physicians Annual Scientific Meeting, Westin Bonaventure, Los Angeles, CA, Contact: American Academy of Family Physicians, 1740 W. 92nd Street, Kansas City, MO 64114 (816) 333-9700.

24-27, American Neurological Association, New Orleans, Contact: American Neurological Association, 2221 University Avenue SE, Suite 350, Minneapolis, MN 55414 (612) 378-3290.

24-28, American Academy of Otolaryngology — Head and Neck Surgery Annual Scientific Meeting, New Orleans, LA, Contact: American Academy of Otolaryngology — Head and Neck Surgery, 1101 Vermont Avenue, N.W., Suite 302, Washington, DC 20005 (202) 239-4607.

October

11-15, American Academy of Child and Adolescent Psychiatry, New York, NY, Contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue NW, Washington, DC 20016 (202) 966-7300.

14-18, American Society of Anesthesiologists Annual Meeting, New Orleans, LA, Contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068 (312) 825-5586.

15-20, American College of Surgeons Annual Scientific Meeting, Atlanta Hilton and Towers, Atlanta, GA, Contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611 (312) 664-4050.

19-22, American Society of Internal Medicine Annual Meeting, J.W. Marriott, Washington, DC, Contact: American Society of Internal Medicine, 1101 Vermont Avenue, N.W., Suite 500, Washington, DC 20005 (202) 289-1700.

21-25, American College of Gastroenterology Scientific Meeting, Marriott Hotel, New Orleans, LA, Contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

21-26, American Academy of Pediatrics Annual Meeting, Chicago, IL, Contact: American Academy of Pediatrics, 141 Northwest Point Road, P. O. Box 927, Elk Grove Village, IL 60007 (312) 288-5005.

MEETINGS

28-11/3, American Society of Clinical Pathologists Annual Scientific Meeting, Ramada Renissiance, Washington, DC, Contact: American Society of Clinical Pathologists, 2100 W. Harrison Street, Chicago, IL 60612 (312) 738-1336.

28-11/3, College of American Pathologists Annual Scientific Meeting, Washington Ramada, Washington, DC, Contact: College of American Pathologists, 5202 Old Orchard Road, Skokie, IL 60077 (312) 966-5700.

29-11/2, American Academy of Ophthalmology Annual Meeting, Convention Center, New Orleans, LA, Contact: American Academy of Ophthalmology, P. O. Box 7424, 655 Beach, San Francisco, CA 94120 (415) 561-8500.

29-11/3, American Society of Plastic and Reconstructive Surgeons Annual Scientific Meeting, San Francisco Hilton, San Francisco, CA, Contact: American Society of Plastic and Reconstructive Surgeons, 233 N. Michigan Avenue, Suite 1900, Chicago, IL 60601 (312) 856-1818.

29-11/4, Congress of Neurological Surgeons Annual Meeting, Atlanta, GA, Contact: Congress of Neurological Surgeons, University of Southern California, 1200 N. State Street, Los Angeles, CA 90033 (213) 226-7421.

30-11/3, American Academy of Occupational Medicine Annual Meeting, Sheraton Inner Harbor, Baltimore, MD, Contact: American Academy of Occupational Medicine, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312) 228-6850.

Other Meetings

June

2-4, Update in Cardiology & Gastroenterology, Amway Grand Plaza Hotel, Grand Rapids, Michigan, Contact: Debra DeSmyther, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400.

5-6, Third Annual Cardiology Symposium for Nursing, Ford Auditorium, University Hospital, Ann Arbor, Michigan, Contact: Pattie Goble, Office of Continuing Medical Education, G1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 936-9800.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain informatin. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

May

31-6/2, Current Topics in Blood Banking: 16th Annual Symposium and Workshops. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

June

1-2, Fifteenth Annual Symposium for Michigan Neonatologists and Neonatal Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Neonatology Service, Bronson Methodist Hospital, (616) 341-6469. **Approved for:** 7.25 hours Category I Credit.

1-2, Gull Lake Conference. Location: MSU Kellogg Biological Station, Hickory Corners, Michigan. **Sponsor:** MSMS Committee on Maternal and Perinatal Health. **Contact:** Katie Brewbaker, Chief, Support Services, Michigan State Medical Society, P. O. Box 950, East Lansing, MI 48826-0950 (517) 337-1351. **Approved for:** 6 hours Category I Credit.

2, Ultrasonic Liver Surgery. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School Parenteral and Enteral Nutrition Team and Department of Surgery. **Contact:** Betty Phillips, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, U-M Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 8 hours Category I Credit.

5-6, Third Annual Cardiology Symposium for Nursing. Location: Ford Auditorium, University of Michigan Hospital, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 12 hours Category I Credit.

7-9, The 7th Annual Clinical Laboratory Computer Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 15 hours Category I Credit.

17, Self Protection: AIDS and Hepatitis. Location: Michigan Inn, Southfield, Michigan. **Sponsor:** University of Michigan Medical School, East Central AIDS Education and Training Center. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category I Credit.

19-23, 25th Annual Northern Michigan Summer Conference. Location: Shanty Creek – Schuss Mountain, Bellaire, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

July

20-21, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Munson Medical Center, Traverse City. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386 (616) 922-9546. **Approved for:** 9-13 hours Category I Credit.

23-26, 3rd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

August

6-9, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Internal Medicine. **Contact:** GAyle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

18-21, Cardiology Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

25-28, 15th Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

25-27, Endocrinology and Diabetes Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 7 hours Category I Credit.

September

7-8, The Practice of Clinical Nutrition: Science & Application for the Future. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School Parenteral and Enteral Nutrition Team and Department of Surgery. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

CATEGORY I COURSES

11-12, **Epilepsy Advances. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Neurology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

11-16, **Pediatric Board Review. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Michigan Association of Pediatric Program Directors, and American Academy of Pediatrics. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 59 hours Category I Credit.

14-16, **Recent Trends in Clinical Electrophysiology: Intraoperative Monitoring. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

21-23, **The National Conference on Pediatric Trauma. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsors:** Kiwanis Pediatric Trauma Institute, New England Medical Center, University of Michigan Medical School, General Motors Corporation. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

21-24, **34th Annual ACP-Michigan Chapter/MSIM Regional Meeting. Location:** Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** American College of Physicians, Michigan Chapter and the Michigan Society of Internal Medicine. **Contact:** Patrick C. Alguire, MD, FACP, Department of Medicine, Michigan State University, B-301 Clinical Center, East Lansing, MI 48824 (517) 353-5100. **Approved for:** 18.5 hours Category I Credit.

October

2-3, **Update on Pulmonary and Critical Care Medicine. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

4-6, **A Symposium on Neonatal Respiratory Disorders. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

5-7, **12th Annual Seminar in Diagnostic Ultrasound. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

12-14, **20th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location:** Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids, Michigan. **Sponsors:** MSU College of Human Medicine, International Federation of Societies for Surgery of the Hand, Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Bldg., 1900 Wealthy S.E., Suite #290, Grand Rapids, MI 49506 (616) 774-0440. **Approved for:** 18 hours Category I Credit.

19-20, **New Approaches to Patient Care in Diabetes: Psychosocial & Behavioral Issues. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Michigan Diabetes Research and Training Center, Michigan Affiliate — American Diabetes Association. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 13 hours Category I Credit.

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PRESIDENT'S PAGE

Professional Liability Still a Top Priority for MSMS

By Robert E. Paxton, MD

It is quite coincidental that since my inaugural as your president, the first issue of *Michigan Medicine* is dedicated to professional liability. Although it wasn't planned that way, the subject certainly is not new to me. I have been very much involved with the problem. First of all, I have worked closely with Carl Gagliardi, MD, who was our point man in the fight for tort reform. Now I am chairman of the MSMS Professional Liability Task Force and I feel that I have been scarred from the battles and well-seasoned by the frustrations that seem to surround us. Furthermore, I feel that professional liability should remain a priority with MSMS. I feel that we should continue to dedicate resources and energies toward resolution of the problem until the crisis is truly over.

Having said that, I realize that as president, I must be involved with a variety of concerns confronting the physicians whom I serve. I am aware that there are numerous other problems and activities that deserve the attention of MSMS and its leaders.

Three major priorities

My priorities for my term in office include maintaining unity in the profession, promoting greater grassroot input, and developing a workable solution for the liability issue that can be realistically pursued.

I am convinced that, if we are to have a viable and effective medical society, we must eliminate all lethargy. We must capitalize on the momentum that is evident and encourage greater involvement by the membership in society activities. It is imperative that the grassroots exert more influence in the making of MSMS political policy. To help achieve this end, I plan to present discussion on my "President's Page" each month to stimulate input and response. The subjects will not be chosen to be confrontational but rather important items that need our attention and a unified effort for resolution.

Standards of care guidelines

To initiate a dialogue on some of the more controversial subjects on our agenda, I want to write about standards of care guidelines. Many of us refer to this in a derogatory manner as "cookbook" medicine. The truth of the matter is that this subject has ramifications into risk management, professional liability, quality of care, and cost containment. Many abhor the concept embodied in "cookbook" medicine, but at the same time, recognize that the profession must establish some guidelines if we are going to take the lead in these arenas.

There are numerous problems involved in developing standards of care. Promoted as a risk management tool, its very structure can come back to haunt us in the courtroom. Presented as guidelines for quality of care, it could have doubtful effects since we are dealing with an inexact science that must accommodate a wide divergence of opinion. Furthermore, guidelines based solely on quality would probably have a negligible effect on containment of costs. Finally, "cookbook" medicine designed to establish an economic-driven health care system, rather than a quality motivated one, would be anathema to most physicians.

In view of these and other problems, should MSMS promote the development of standards of care guidelines? The answer may be complex but the superficial reality is that if we don't do it ourselves, a non-physician entity will do it for us. Traditionally, we have always been concerned about quality of care and know that it is important to maintain a quality-mandated health care system. At the same time, we are very much concerned about the appropriateness of care and would encourage the sanction of physicians who abuse the system for financial gain. When all is said and done, it becomes apparent that as we work in the current health care environment we must assume the task of guideline development.

The question that confronts us is how to proceed? Specifically, as the umbrella organization, we could coordinate specialty societies in this direction and make the resultant standards of care available to our members. We could be the clearinghouse for risk management activity which would include both guidelines for physicians and patient education. This might be facilitated with written and video material prepared by the MSMS Department of Communications and Professional Relations for the membership.

Perhaps the greatest challenge for us would be to devise guidelines or parameters that could produce effective cost containment while at the same time, assuring quality of care for our patients. Innovative attempts by MSMS, working in conjunction with third party payors, might be of immeasurable service to the public as well as to our profession.

Space limits any indepth discussion of this subject. My purpose in this article is to encourage a response from you (MSMS members) regarding the concept in general and specific suggestions for implementations. One important question that needs to be answered is how will the profession react to quality of care standards established by their professional organization? The topic is timely and important. Let us hear from you! ■

Doctor Paxton is MSMS President.

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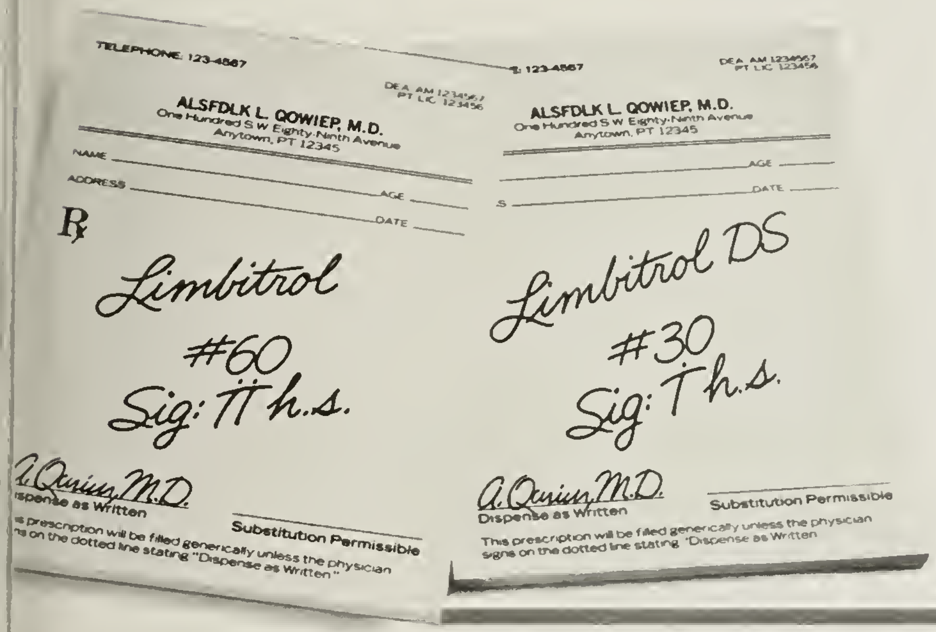

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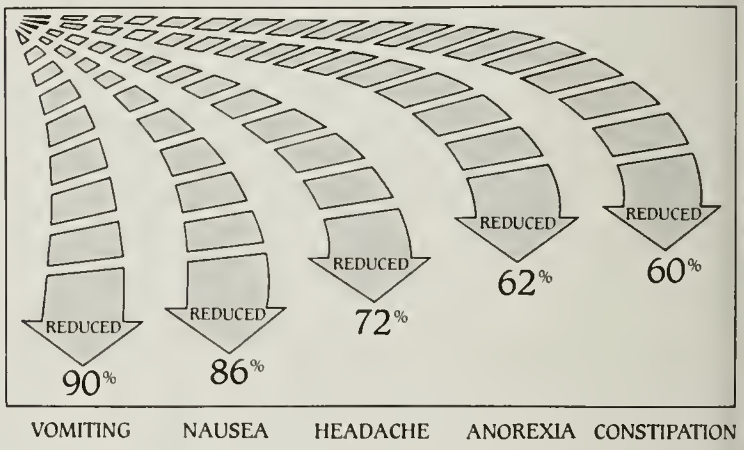

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JUNE 1989
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A record number of resolutions in recent memory confronted delegates to the 1989 MSMS House of Delegates meeting May 5-7 in Dearborn. The total reached 154, twice as many as considered in 1988. In addition, the House of Delegates made history by approving the first medical society Section for Graduates of Foreign Medical Schools. MSMS delegates also set precedent by naming the first woman physician to serve as president-elect. These and other highlights of the MSMS House of Delegates meeting are the subject of this month's cover story.

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In next month's issue of *Michigan Medicine*: Practice Management.

Cover illustration by: *Robert L. Brent.*

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IN MY OPINION

Physicians Can Be Proud of MSMS

By Carl F. Hammerstrom, MD

The invocation for the 1989 MSMS House of Delegates Meeting given by Gerald F. Conway, MD (Oakland County delegate), was most fitting. It went as follows:

"Good Lord, we need your help. Every year at this time a group of concerned physicians meet to see if they can make some sense out of Michigan's health care policy, and to try to establish policies for the Society. Every year you're asked to bless this assembly. Here we are again, and again we address you before we make any major decisions.

"We need your help in our deliberations so we can keep our priorities straight. We ask you to continually remind us this weekend that we are not just representing hospital medical staffs, or medical students, or foreign medical graduates, or young physicians, or female physicians. Rather, our ultimate responsibility is to our patients. If the results of this meeting benefit our patients, we will have been successful.

"We, therefore, ask you for your help and for your blessings on this assembly in the name of our patients."

One-hundred-and-fifty-four (154) resolutions and 13 Board action reports were debated by seven reference committees at the House of Delegates Meeting. With the assistance of senior MSMS staff members and an efficient word processing and production center, committee reports were written, typed and printed Saturday and made available to the delegates by 8 a.m. Sunday.

I have participated in MSMS committee activities, the Annual Scientific Meeting, the House of Delegates, and Board of Directors meetings for the past 15 years. The competence and personal qualities of the MSMS staff and their well-organized facilitation of physician participation in Society activities has made me proud and confident of the Society's future.

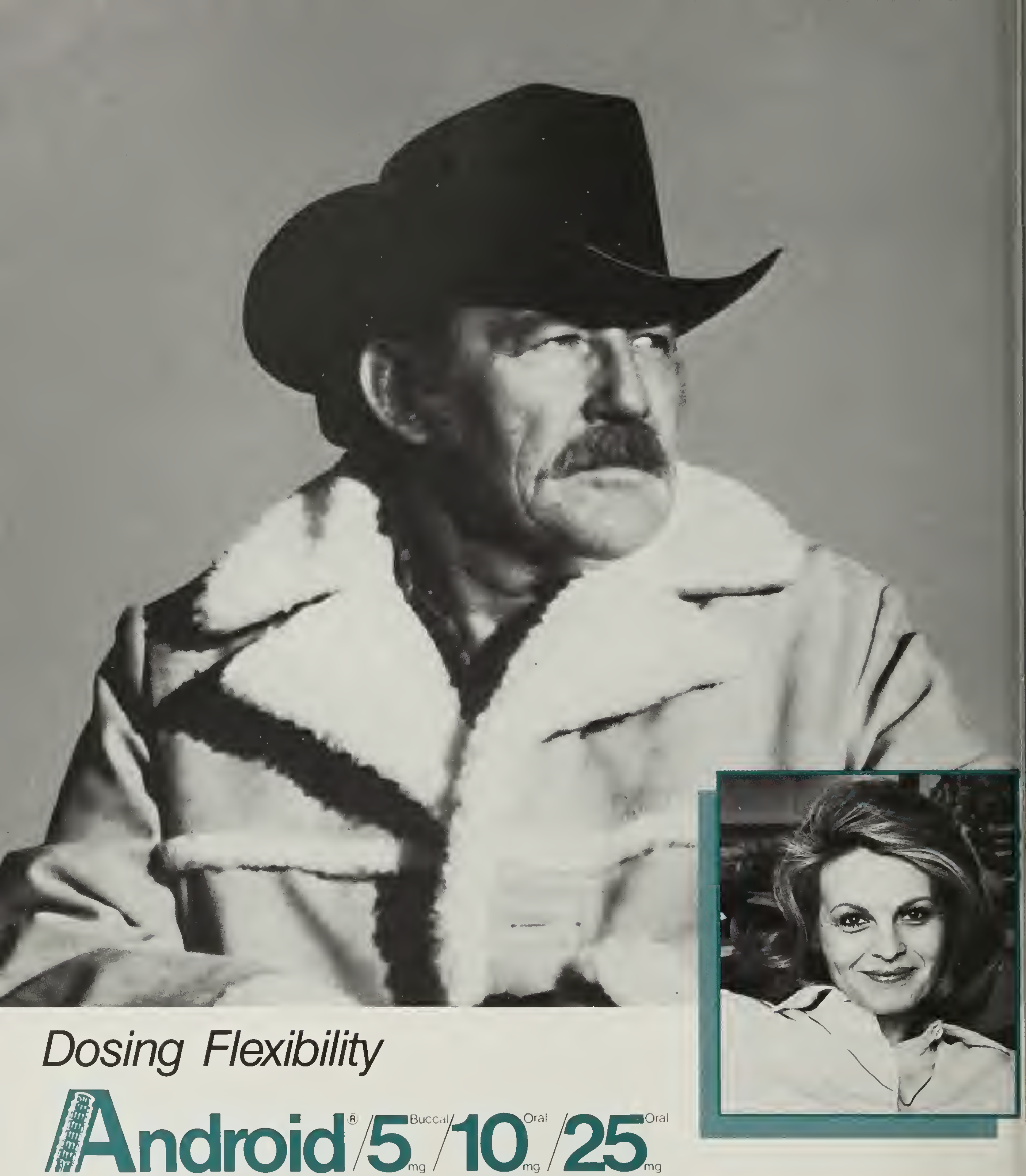
Behind the reports MSMS members receive is a vast amount of member physician involvement. The 43 pages of committee reports in this year's Delegates Handbook represent the work of more than 500 volunteer committee members.

You can be proud of your society and its work. Please join us in county and state committee activities. Observe the competence and dedicated involvement of hundreds of the best of your colleagues.

MSMS staff will assure that your involvement in the work of the Society will be as efficient as possible, accurately recorded, and reported to fellow members.

Tell others what you observe of your medical society. This is our strength. Encourage your colleagues to join us and support the Society with your dues contribution and personal involvement in our activities. ■

Doctor Hammerstrom is a member of the MSMS Board of Directors and serves on the MSMS Committee on Publications.



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Letters from Our Readers

Nominations needed for first World Medical Prize

Howard University Hospital, located in Washington, DC, is calling for nominations for the first Dr. Charles R. Drew World Medical Prize.

Howard University Hospital has established an awards endowment fund to recognize the achievements of persons of color who have made significant contributions in public health, health research, or the delivery of health care. This year, two prizes of $50,000 each will be awarded to two individuals — one from the United States and one from a developing country.

Nominations must be received no later than August 1, 1989; recipients will be notified by September 1.

For further information on the awards program, please contact the Awards Committee Chairman: LaSalle D. Leffall, Jr., MD, Dr. Charles R. Drew World Medical Prize Award Committee, Department of Surgery, Howard University Hospital, 2041 Georgia Ave., NW, Washington, DC 20060 (202) 865-1441.

Jacque Boyd
Howard University Hospital
Washington, DC

Consumers need to be educated about SIDS

Seven thousand infants will die this year of Sudden Infant Death Syndrome (SIDS) — the country's number one cause of death between one week and one year of age. In this state alone, approximately 250 families will experience the unexpected and unexplained tragedy of losing a child to SIDS.

We are the local (North-Central-Southwest Michigan) chapter of the National SIDS Foundation. Staffed by a dedicated team of volunteers, we offer emotional and educational support to bereaved parents, families and friends through one-on-one contact with "grief companions," who have experienced the same emotional trauma; group support meetings; and distribution of informational material.

SIDS is a community concern, and one in which we ask for your help in educating local citizens. For instance, explaining that SIDS is unpreventable and unpredictable can help relieve grieving parents of the false burden of guilt.

In addition to education, we ask for your help in spreading the word about how consumers can help further SIDS research. By purchasing private label disposable diapers marked with the highly visible "Compare and Save Seal of Quality," and redeeming this seal, parents can make a contribution in their name to the National SIDS Foundation.

Consumers can quickly locate these diapers by calling toll-free 1-800-COMPARE. Locally, these diapers are available at Spartan Stores, Krogers, K-Mart, Toys-R-Us and Food City.

We encourage you to call us if you would like more information or if you have any questions.

Audrey Putnam
Administrative Assistant
North-Central-Southwest MI Chapter
National SIDS Foundation

Melvindale physician remembered

Max L. Lichter, MD, one of the most influential delegates in the MSMS House of Delegates during the 1950s and 1960s, died March 21 at the age of 79.

Throughout his medical career, Doctor Lichter served as chairman of several Wayne County Medical Society committees. He also served as chief of staff for six years at Oakwood Hospital, Dearborn, and as a practicing family physician in Melvindale for 41 years. Not to be forgotten is the important role Doctor Lichter played as chairman of the MSMS Medical Care Insurance Committee, the parent committee for the MSMS Relative Value Scale Committee.

I worked closely with Doctor Lichter as the MSMS staff assistant to the MCIC and RVS committee and later with Doctor Lichter in my position as the executive of the Michigan Health Council.

Pages are devoted in the late 1950s and early 1960s to annual reports of the Medical Care Insurance Committee, which provided physician leadership and participation in efforts to assure quality medical care through Michigan Medical Service policies to Michigan workers and the elderly. MSMS was instrumental in the birth of the Michigan Medical Service (Blue Shield) in 1920.

The Medical Care Insurance Committee — after hearings with medical specialty societies, major employers, unions and others — recommended to the MSMS House of Delegates that physicians agree to unit values that would be increased for those persons earning not more than $7,500. A reported 80 percent of Michigan subscribers were served.

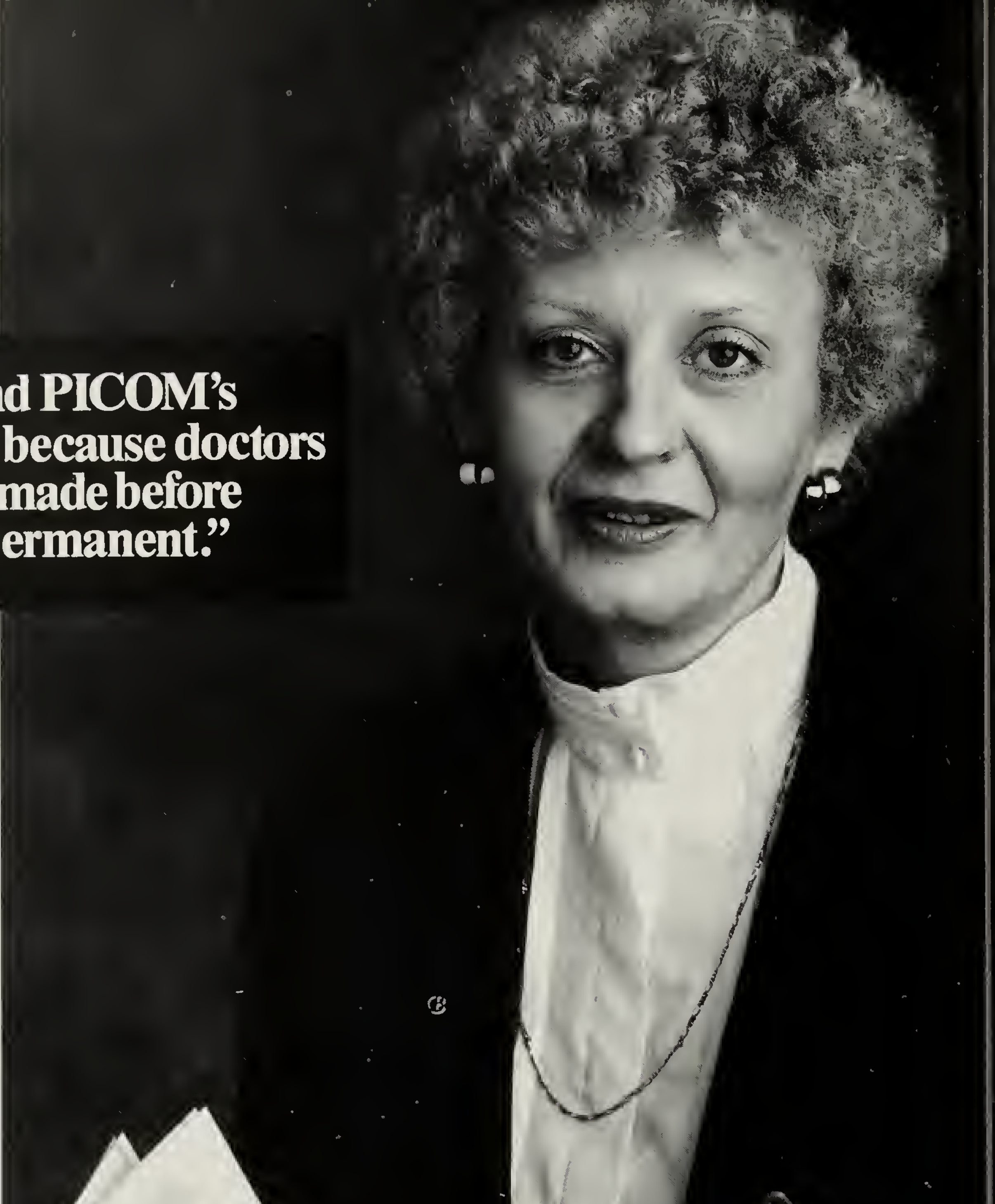
Doctor Lichter, during all these committee meetings, reports to the House of Delegates, relationships with Blue Shield and specialty organizations, became a leading authority on prepaid medical care philosophy and operation. He had the uncanny ability to summarize views, propose courses of action and lead with enthusiasm and dedication.

Doctor Lichter was a delegate to the MSMS House from the Wayne County Medical Society, where he also served for a time as an associate editor of *Detroit Medical News*.

Highly regarded and loved by his Melvindale area patients for more than four decades, Doctor Lichter later became an early physician leader in Michigan in the health promotion movement. In 1982, he was awarded a grant from the W.K. Kellogg Foundation for the Oakwood Hospital Community Health Promotion Project. Doctor Lichter and the hospital conducted a vigorous effort to determine health care needs of area residents. The findings were reported back to the Kellogg Foundation as possible models to be adapted in other states. During this later career in health promotion, he was director of school health services for the Melvindale-North Allen Park school system.

Doctor Lichter was born November 6, 1909, and received his medical degree from Wayne State University. He will be missed.

Herb Auer
Former MSMS Deputy Director



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MEDICAL NEWSFRONTS

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U-M researchers discover protein that may help diagnose colon cancer

Seeds from a bright, purplish herb might hold the key to diagnosing colon cancer in its early stages and identifying people predisposed to the disease.

Researchers at The University of Michigan Medical Center have isolated a new lectin, called amaranthin, from the seeds of the Central American plant that seems to bind to colon cancer cells and premalignant tissues.

If this is true, the finding could alert some people to potential problems while eliminating unnecessary, painful testing for people who are not at risk of developing colon cancer.

Lectins are proteins that are used to map the presence of carbohydrates structure. Amaranthin binds to the T antigen, a cancer-associated carbohydrate structure.

"Long before a tissue becomes cancerous, it undergoes a number of changes, but no one is quite sure how to identify these tissues as precancerous. This lectin may help find these tissues," says C. Richard Boland, MD, U-M professor of internal medicine. Doctor Boland is researching the lectin with U-M researchers Irwin J. Goldstein, associate dean for research and graduate studies and professor of biological chemistry in the Medical School, and Stephen Rinderle, graduate student research assistant.

Currently, a long, tube-like device called a colonscope is inserted into the colon to detect cancer. But, Doctor Boland says, a colonoscopy usually cannot identify premalignant tissue.

"Using amaranthin, we could refine the interpretation of what we see with a colonoscopy, because physicians don't always recognize precancerous tissue with colonoscopy," he says.

Depending on the next series of studies, Doctor Boland says amaranthin could be in widespread use for detecting colon cancer within one or two years.

Approximately 120,000 new cases of colon cancer are reported in the United States each year, and approximately 60,000 people die of colorectal cancer annually, according to Doctor Boland.

State's first mobile kidney stone pulverizer now available

Kidney stone suffers now have access to a unique mobile second-generation lithotripter, which makes kidney stone removal a virtually painless, nonsurgical outpatient procedure. It is the result of a joint venture between Oakwood Hospital, Dearborn, St. John Hospital and Medical Center, Detroit, and Sparrow Hospital, Lansing, known as Michigan Mobile Lithotripsy, Inc.

The mobile technology will rotate between the three hospitals on a weekly basis.

Housed in a mobile medical laboratory, the Siemens Lithostar is Michigan's first mobile lithotripsy unit. It was recently approved by the Federal Food and Drug Administration for mobile usage. Patients utilizing the Lithostar require little or no anesthesia. The unit eliminates the need for a waterbath, a common procedure in past lithotripsy treatment.

Oakwood to build residential complex for senior citizens

Oakwood Health Services Corp. broke new ground May 19 on the first phase of a residential complex for senior citizens called Oakbrook Common. It will be the first hospital-sponsored community in southeast Michigan to provide living arrangements both for independent seniors and for those who need medical and personal care.

Oakbrook Common will feature three levels of living arrangements for area residents: residential apartments for independent adults; assisted living suites for adults who need help with daily tasks; and a skilled nursing facility for those who need 24-hour medical attention. A medical diagnostic center also will be located on the grounds.

"The senior living community will fill a void in housing choices for older adults in the Dearborn area," says Jack Shaw, vice president, Oakwood Medical Enterprises Inc." Currently, there is insufficient housing to meet the needs of Dearborn area residents seeking retirement housing and skilled nursing care within the city."

The community will be built on 32 acres of land just minutes away from Oakwood Hospital, Dearborn.

Construction will continue through the end of the year and into 1990, with apartments expected to be available for occupancy late next year.

New AMA book offers practice management tips

Physicians who plan to start private practices, or those who wish to review the fundamentals of practice management, may wish to acquire the newly-revised and expanded edition of The Business Side of Medical Practice.

Available from the American Medical Association, the book is designed to provide information needed to successfully start and manage a medical practice. Topics new to this edition are computers in the medical office and up-to-date information on the pros and cons of the various legal forms of organizing a practice.

Many chapters in the book focus on deciding how to practice, selecting the place to practice, setting up an office, clearing legal hurdles and securing professional assistance, and the kinds of insurance a physician should carry.

Major helpful tips and guidelines will be found in the chapters on efficiency and office operations, running the business side of practice, billing and collections, and personnel management. Another chapter addresses personal financial planning.

Throughout the book are various forms, charts, and checklists which may be reproduced and used by office staff.

Continued on page 10

Continued from page 9

The Business Side of Medical Practice, 166 pages, OP-410/8, is available for $30 (20 percent discount for AMA members), from the American Medical Association, Book and Phamplet Fulfillment, P. O. Box 10946, Chicago, IL 60610-0946 or call 1-800-826-6895 with VISA or Mastercard to order.

Advance Medical/Medpath holds building dedication at new headquarters

Advance Medical/Medpath, the state's largest clinical laboratory, recently held an open house and building dedication at its new headquarters in Auburn Hills.

The new headquarters building is located near the Palace of Auburn Hills and replaces the laboratory's previous four-building complex, which also was located in Auburn Hills. The new 51,800-square-foot facility includes approximately 25,000 square feet of laboratory space, 17,000-square-feet of office space, and a 9,800-square-foot warehouse. Advance Medical/Metpath's central operations moved to the new site on January 1.

ACP issues challenge on better adolescent health care

Current health care services may not be adequate for adolescents, according to the American College of Physicians (ACP).

The transition from childhood to adulthood is marked by tremendous change, bringing potential behavorial and psychosocial problems for teenagers. Physicians traditionally have not been attentive to these problems or to the more general developmental challenges faced during adolescence, states the ACP.

ACP, the nation's largest medical specialty society, states that health needs of adolescents often are overlooked because childhood diseases are no longer a significant threat and major health problems of adulthood generally have not yet developed.

An updated approach to adolescent medicine is needed, ACP says. Physicians of young patients need to be alert to alcohol, drug and tobacco use, dpression, suicide, eating disorders and physical and sexual abuse. They must be able to talk about birth control, family planning and sexually transmitted diseases, including the acquired immunodeficiency syndrome (AIDS), ACP states.

According to ACP, adolescent medicine should be a greater component of medical school education, residency training and continuing medical education. Physician training programs should focus on health promotion and disease prevention for young adults, because lifestyle choices and health habits during adolescence often determine health status in adulthood.

Leukemia Society now accepting applications for 1990 grants

The Leukemia Society of America is now accepting applications for 1990 grants to encourage research at both the basic science and clinical levels in the fields of leukemia and related diseases.

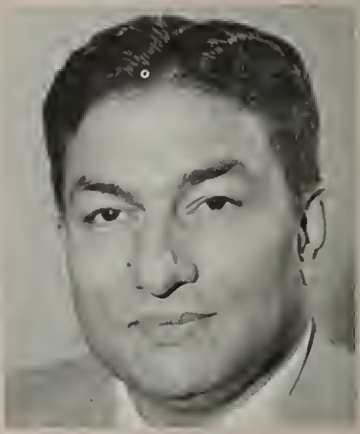
Deadline for applications with the Society is September 1, 1989. Only one application in each category from one faculty sponsor may be submitted. Proposals will be evaluated on a competitive basis by the Leukemia Society's Grant Review Subcommittee in January 1990 with funding to begin July 1, 1990.

For application forms and additional information, write: Research Grant Coordinator, The Leukemia Society of America, 733 Third Ave., New York, NY 10017.

Physicians in the News

Philip M. Margolis, MD, professor of psychiatry, University of Michigan, is the new secretary of the American Psychiatric Society (APA). A Life-Fellow of the APA, he served as co-chair of the Quality Care Task Force which last fall completed its survey of Michigan's Mental Health Services. He has been active with ethics issues and was president of the Michigan Psychiatric Society in 1980-81. Doctor Margolis is a consultant to the US Department of Justice and to the Center for Forensic Psychiatry, Ann Arbor.

Raymond A. Gagliardi, MD, a Pontiac radiologist, is the most recent recipient of the American Roentgen Ray Society Gold Medal Award. The award is given in recognition of his outstanding contributions to the field of radiology. Doctor Gagliardi is chief radiologist at St. Joseph Mercy Hospital, Pontiac, and is an associate professor of clinical radiology at Wayne State University. He has been very active in the American Roentgen Ray Society acting as secretary from 1980-1986, president-elect from 1986-87, and president and chairman of the program committee from 1987-88. Doctor Gagliardi is also involved with the Radiological Society of North America, the American College of Radiology, and the American Medical Association.



Busharat Ahmad, MD, a Marquette ophthalmologist, recently conducted an International Seminar sponsored by the Eye Bank Association of America and the Pakistan Eye Bank Society. The seminar was held in Karachi, Pakistan, February 23-28. The main goal of the seminar was to help Pakistan and the other surrounding countries become more self-sufficient in corneal tissue for transplantation and to eradicate corneal blindness. Doctor Ahmad, three American corneal surgeons, and six experts in administration and technical skills in eye banking, instructed approximately 200 people at each seminar session. Members of the Eye Bank Association of America team, in addition to Doctor Ahmad, included Alan Sugar, MD, and Mary Beth Danneffel, both of Ann Arbor. Doctor Ahmad is chairman of the MSMS Section for Graduates of Foreign Medical Schools and is a former MSMS Board member. He is an alternate delegate to the American Medical Association and is past president of the Eye Bank Association of America.

Continued from page 11

Pierre F. Giammanco, MD, a Bloomfield Hills specialist in cosmetic surgery, will present five papers at the Third International Congress of the International Society of Aesthetic Surgery. Doctor Giammanco will be the only surgeon representing Michigan at the meeting. He has also been asked to co-chair the session along with the French surgeons. Doctor Giammanco received his education and training at the Wayne State University College of Medicine and graduated in 1964. He is on staff at St. Joseph Mercy Hospital, Pontiac, Crittenton Hospital, Rochester, and Detroit Receiving Hospital, Detroit. Doctor Giammanco is certified by the American Board of Otolaryngology and the American Board of Cosmetic Surgery and is a member of the American Academy of Facial Plastic and Reconstructive Surgery.

Elie D. Aboulafia, MD, a Farmington Hills vascular surgeon, is the new president-elect of the International College of Surgeons - US section.

Robert H. Hodge, Jr., MD, is the new president of the American College of Physician Executives. He has been an active member of the College since 1979 and has served on the Board since 1985. He was elected president during the 14th Annual National Conference on Health Care Leadership and Management held May 3.

Lawrence Pasik, MD, of West Bloomfield, is the new president of the Michigan Allergy Society. Doctor Pasik is a graduate of SUNY Downstate Medical Center and has been on staff at the Henry Ford Hospital in Detroit. He is also a member of the American Academy of Pediatrics, the American Academy of Allergy, and the Detroit Pediatric Society. Other newly-elected officers are: **Carl Lauter, MD,** president-elect; **James Fordyce, MD,** secretary; and **Ling Shih, MD,** treasurer.

Sheldon N. Siegel, MD, chief of psychiatry, William Beaumont Hospital, is the newly-elected president of the Michigan Psychiatric Society (MPS). Formerly president-elect of the 1,100-member society, Doctor Siegel is Board Certified in Psychiatry and is a Fellow of the American Psychiatric Society. He is also certified by the American Board of Quality Assurance and Utilization Review. Other newly-elected officers include: **Lionel Finkelstein, MD,** president-elect; **Diana Constance, MD** and **John F. Greden, MD,** councilors and members-at-large.

Cecelia F. Hissong, MD, is now a certified expert in the field of chemical dependence. She passed the six-hour exam given by the American Medical Society on Alcoholism and Other Drug Dependencies and was awarded her certificate during the Society's 35th Annual Medical Scientific Conference on April 29. Doctor Hissong is currently a family physician on staff at the Oakwood Hospital and has a private practice in Dearborn. She is also active at the Oakwood Downriver Medical Center in Lincoln Park.

Michigan State Medical Society

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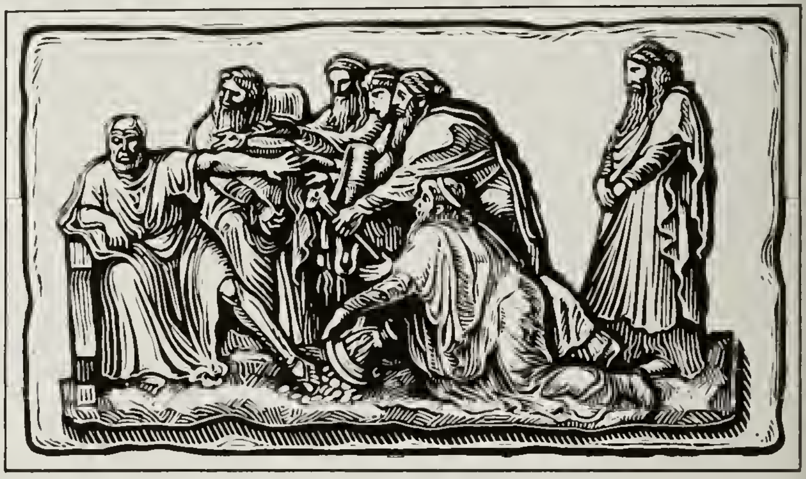
OVER A CENTURY AGO, a thousand visionary physicians across the nation bestowed a commemorative stone carving to the Washington Monument. This patriotic display symbolized their unrelenting devotion to a new republic founded on freedoms—including the freedom to practice medicine for the best possible health of all its people. *Today your help is needed to restore this symbol of our profession.*



Because the commemorative stone has suffered from severe erosion and defacement, the American Medical Association is launching a campaign to raise money from physicians to restore this symbol of medicine for the National Park Service. Every contribution made to this effort will serve as a statement of each physician's personal affirmation and commitment to health and medicine in America.

Please take part in rededicating the commemorative stone as a shining example of the strength of medicine in a free and strong society.

Contributors who donate $100 or more will receive a memorial replica of the carving as a token of appreciation. Send your tax deductible contribution for this timeless symbol today. Thank you.

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MSMS HOUSE OF DELEGATES

▪ MEETING HIGHLIGHTS ▪

MICHIGAN STATE MEDICAL SOCIETY

A record number of resolutions in recent memory confronted delegates at the 1989 MSMS House of Delegates meeting May 5-7 in Dearborn. The total reached 154, twice the number in recent years. The speakers and delegates handled the extra load by creating an additional reference committee, and by starting business sessions early.

The MSMS medical school Class of 1939 held a reunion during the MSMS annual meeting. Thirty-one physicians received 50-year pins in special ceremonies.

Photographic coverage of House of Delegates meeting by Pattrick Yockey

A visual highlight of the annual meeting this year was the display of photos of all but one MSMS president since the founding of the Society in the 1800s. Delegates and guests enjoyed the photographic review and the memories it evoked.

MICHIGAN STATE

The transference of the MSMS presidency was marked with the presentation of the official lavaliere during the installation ceremony. Passing the title to his successor, Robert E. Paxton, MD, Fremont, (right), is Fred W. Bryant, MD, Royal Oak, 1988-89 MSMS president.

Active leadership is nothing new for pediatric surgeon Susan Hershberg Adelman, MD, who, next year, will be the first woman to preside over the 124-year-old Michigan State Medical Society.

In 1983-84, Doctor Adelman served as president of the Wayne County Medical Society and for the past nine years has edited the Detroit Medical News. *A prolific writer, Doctor Adelman is a regular contributor to the American Medical Association's* AM News *and has published numerous articles in various medical journals and publications.*

From 1980 to 1986 Doctor Adelman was a member of the Blue Cross/Blue Shield of Michigan Board of Directors and currently serves as chairman of the MSMS/BCBSM Liaison Committee. In the area of managed care, Doctor Adelman serves as Medical Director for Program Development with Detroit Medical Center Coordinated Health Care and in 1983 was active in establishing the Physicians Primary Sponsor Plan for Medicaid recipients in Wayne County.

Doctor Adelman, a 1962 graduate of the University of Michigan and a 1967 graduate of Wayne State University School of Medicine, has a private practice with offices in Dearborn and the Detroit Medical Center.

During her coming years in MSMS leadership, Doctor Adelman said she will work to increase the role of MSMS as a patient advocate and resource in the development of Michigan public health policy. She also will encourage increased volunteer activities by individual MSMS members, particularly in programs benefiting the underserved.

HOUSE CONSIDERS 154 RESOLUTIONS

MICHIGAN STATE MEDICAL SOCIETY

Delegates to the 124th annual MSMS meeting May 5-7 in Dearborn set precedent in three areas:

1) They named the first woman physician to serve as president-elect. She is Susan Hershberg Adelman, MD, Detroit pediatric surgeon and MSMS Board member. Doctor Adelman is an AMA delegate, chairs the MSMS/Blue Cross Blue Shield of Michigan Liaison Committee, and is past president of the Wayne County Medical Society. At her election, she expressed her readiness to do her best for MSMS, and described her interests in seeing MSMS members serve as resources for public health agencies, and as volunteer care-givers for the needy. She also said she will welcome underrepresented groups to MSMS activities.

2) They approved, on final reading, the new MSMS Section for Graduates of Foreign Medical Schools, the first of its kind in the nation. Section delegate Samir Yahia, MD, Detroit, immediately took his official seat in the House of Delegates. "We promise the Society we will work toward involvement of graduates of foreign medical schools in MSMS, and toward the unity of all physicians," said Section Chairman Busharat Ahmad, MD, Marquette. "This is an historic event in this nation," said MSMS President Robert E. Paxton, MD. "I have shared the hard work of this group in reaching this goal, and my belief in unity is strengthened. Welcome to all of you."

3) They dealt with the largest number of resolutions — 154 — submitted to any MSMS House of Delegates in recent memory. The resolutions called for MSMS action on everything from professional liability to assault rifles. To manage the deluge of resolutions, reference committees and the full House convened early Saturday and Sunday mornings. In addition, the speakers created a second committee to share the load in the medical care delivery area.

Highlights of the delegates' actions follow:

PROFESSIONAL LIABILITY

Supported continued MSMS study of alternatives to the tort system to compensate injured patients. Alternatives cited included the AMA/Specialty Society Liability Project, and a reworking of the Swedish liability system.

Supported state payment of liability costs for physicians providing Medicaid services.

Called for work with specialty societies to establish statewide panels of physicians to serve as expert witnesses in liability cases.

Established policy that expert witnesses must be in the same specialty as the plaintiff physician at the time of the alleged incident.

Called for physician selection for mediation panels to be an administrative process, rather than a choice of the litigants.

Referred to the Board a resolution to "take all possible steps" to stop Blue Cross Blue Shield of Michigan from joining the plaintiff in liability cases, and from thereby placing the physician in an adversarial position. The delegates called on the Society to determine how often such a situation occurs.

LEGISLATION

Initiated MSMS efforts for legislation allowing the Board of Medicine to handle impaired physicians in confidence and to use MSMS programs to provide for early referral of MDs, to hasten the therapeutic process. Delegates stressed the need for anonymity, but called for the treatment process to be reported to the Board of Medicine, to assure oversight.

Supported legislation to expand the Good Samaritan Law to physicians who treat patients on an emergency basis in Michigan hospitals.

Supported proposed new legislation and/or regulation to give individual EMS medical directors the authority to promulgate their own protocols, polices and personnel rules.

Called for establishment of a blood alcohol concentration of 0.05 percent as illegal for driving in Michigan. The delegates also want administrative license revocations in arrests for operating under the influence, mandatory blood alcohol testing for any driver involved in motor vehicle accidents resulting in serious or fatal injuries, color-coded licenses for persons under 21 years of age, and mandatory alcohol treatment and counseling for repeat offenders.

Sought legislation to amend the law limiting comparative negligence for not using a seat belt to five percent, and to require front seat passengers in vehicles which have detachable restraints to have them properly adjusted, fastened and working.

Called for legislation to prohibit vending machine sales of tobacco products.

Supported amending the law to allow forfeiture of real property used in committing violations of the substance abuse act, with 50 percent of the property thus forfeited to be used to support community-based educational and substance abuse treatment programs.

MEDICAL CARE DELIVERY

Supported the availability of long-term care insurance for Michigan citizens.

Requested the AMA to work with Congress to extend DRG reimbursement for patients whose hospitalization is prolonged because of the Medicare Catastrophic Coverage Act.

Called for MSMS to inform the public about the minimum coverage under Medigap or Med-Supp insurance, for the Insurance Bureau to distribute such information to senior citizens, and for the Bureau to require fact sheets with all such insurance policies.

Mandated an MSMS study on the public health effects of cost containment programs.

Asked the AMA to recommend the Health Care Financing Administration change its Medicare Quality Intervention Plan (QIP) so that quality indicators are made only by physicians, so that physicians are notified when mismanagement is alleged, and so that "significant adverse effect" is more narrowly defined to allow individual physicians to evaluate their patients in regards to the regulations.

Directed MSMS to pursue educational activities to apprise physicians of the implications of the indexing system of QIF and the potential disciplinary actions that can result.

Initiated steps to require that Medicaid provide review criteria for authorizing hospital admissions to all physicians and hospitals requesting prior authorization.

Urged MPRO to work with MSMS and the Michigan Hospital Association to develop appropriate procedures addressing issues of fragmented care, before applying sanctions; urged MSMS to remind MPRO of HCFA's recent acknowledgement that fragmented care issues do not of themselves imply that standards of care have not been met, and encouraged the AMA in its efforts to improve HCFA guidelines for fragmented care payments.

Vowed to work with Michigan specialty societies to develop qualifications for PRO physician reviewers, to get MPRO to use the qualifications in selecting reviewers, to recommend that reviewers must be physicians from the same specialty, and to encourage qualified specialists to actively participate as PRO reviewers.

Asked the Michigan AMA delegation to request the AMA seek a HCFA requirement for specialty-specific physician reviewers in cases of alleged substandard quality of care.

Requested the AMA to get HCFA to change the proposed "Quality Denial Model Letter" to be issued by its PROs, to issue those letters only after review is complete and the physician has been afforded due process, to notify all involved parties by letter immediately after a denial is overturned (in those cases in which the denial letter is sent prior to completion of due process). The delegates want HCFA to state in any denial letter sent before due process is complete that the MPRO determination is subject to review and may be reversed.

Called for the AMA to work with HCFA to reduce "the onerous demands" for medical records and chart review, to reduce or clearly demonstrate the necessity of 25 percent case review, and to inform Congress of the burden cost containment measures impose on hospitals.

Requested MPRO to adopt a policy that MSMS, in consultation with specialty societies, develop written screen criteria for MPRO reviewers.

PUBLIC HEALTH

Requested a delay in implementation of new workers compensation health care services rules and fee schedule to allow for physician input.

Supported development of publicly-funded pilot projects in areas of need to address specific adolescent health needs including pregnancy, suicide, alcohol and drug abuse.

Called for MSMS to initiate legislation to permit the dispensing of contraceptives through school-based health programs.

Called for expanding the new laws requiring AIDS education in schools to include STDs.

Supported legislation authorizing hospitals certified for more than 100 beds to establish 10 percent of beds for swing shifts in short term nursing care.

Asked the AMA to call for evaluation of national policy regarding disposal of low-level radioactive waste, called for a coordinated national policy, and asked MSMS to seek protection of Michigan's natural resources from pollution by low-level radioactive wastes.

Urged MSMS members to continue voluntarily to cooperate with the state to find adequate ways to dispose of medical wastes, and encouraged state government to develop rules for such.

Encouraged all high-risk individuals to receive hepatitis B vaccine and immune globulin if indicated, and for the state to provide both at no cost for all high-risk indigent and Medicaid patients.

Initiated steps for legislation to restrict solicitation of prescriptions by vendors of durable medical goods.

Called for joining with the Michigan Hospital Association in directing legislative and public relations resources to call attention to the Medicaid crisis.

Called for a complete review by the Michigan legislature of Medicaid reimbursement levels and billing procedures.

MEDICAL EDUCATION

Resolved to work with the Michigan Department of Licensing and Regulation and the Michigan Board of Medicine to expedite the physician licensing process and to develop educational materials describing licensure requirements.

Endorsed the legislature's proposed health professional recruitment strategy for encouraging physicians to practice in underserved Michigan areas.

Set MSMS policy banning discrimination in licensure, licensure by endorsement, job promotions, hospital privileges, reimbursement, residency medical staff and academic appointments, professional society memberships, financial aid and board certification solely on the basis of being a graduate of a foreign medical school.

Called for MSMS to work with the legislature to enact the AMA model bill allowing graduates of both foreign and US medical schools to meet the same requirements for licensure by endorsement.

Encouraged MCGME and MAME to develop and maintain a data bank on open residencies.

Opposed the mandatory centralization of postgraduate medical training under the auspices of the nation's medical schools.

Encouraged the State Board of Education to require that physicians perform or coordinate school athletic examinations. ■

INAUGURAL ADDRESS

UNITY GIVES US STRENGTH, Says Robert E. Paxton, MD

Following are excerpts of Doctor Paxton's inaugural address which was given during the MSMS House of Delegates Meeting, May 6, in Dearborn.

Thomas R. Berglund, MD (left) swears-in Robert E. Paxton, MD, as the 124th president of MSMS.

Robert E. Paxton, MD, presents his inaugural address.

Before we get started I would like to explain a little geography. I do this because I think it's important for you to know where your new president is coming from, literally as well as figuratively. I am a family practitioner...in a small town called Fremont, with a population of about 3,500.

Just south of town is the Muskegon River — a wide, deep, beautiful and powerful river that has always been an important part of the area's history. I cross the Mighty Muskegon River on the Bridgeton Bridge every time I make a trip to MSMS Headquarters in East Lansing. For the past few years, that's been a lot of trips.

When I leave the house on my way to East Lansing, I always start to think about the business I have to attend to when I get there. But when I approach the Bridgeton Bridge, and swoop down from the high plateau into the river valley, I'm always distracted by the beauty and serenity of the river. Day after day, season after season, year after year, the Mighty Muskegon River flows quietly, steadily, toward Lake Michigan. I've thought a lot about the river; where it comes from; what it encounters on its journey to the sea; and I think about its undeniable determination to reach its goal.

Three major goals

The Muskegon River has become a symbol for me. Interestingly enough, it helps me focus the major goals for my presidency of the Michigan State Medical Society, of which there are three: (1) To increase the grass roots participation in all MSMS activity; (2) To work hard to maintain unity in a profession that many would like to see split into competing factions; and (3) To establish realistic, attainable goals for MSMS, particularly in the area of professional liability.

You may be thinking, how does a river help this guy focus his goals? Let me explain.

First. Where does the river come from? It comes from individual drops of water. The billions of tiny water drops working together keep the river flowing. Without this individual participation, the Muskegon River would be nothing but a dry gulch.

It's the same with the Michigan State Medical Society. Fortunately, our active membership committee has kept our numbers increasing, over 11,000 now. But success as an organization requires more than mere numbers on a sheet of paper. People at the state capitol have called the medical society a "sleeping giant" — that if we could just motivate our membership to work together for a specific action, we could be one of the most respected and powerful influences in state government.

So how do we get our membership, the front line grass roots physician, to respond to the challenges facing us? The answers are simple, but so important.

Get politically involved

First, they must get politically involved! Along with the leadership, they must become a part of the process. All of us must personally make our feelings known.

Would you believe that fewer than 50 percent of MD's across the country are even registered to vote? Would you believe that I have US Congressmen and state legislators who tell me they receive on average only about a half-dozen letters a year from physicians? Would you believe that some Congressmen actually have to plead to get physician input to help them make important health issue decisions? Well, believe it. It's true.

Let's get out of our tower and off our pedestal – whatever it takes to meet with our lawmakers. Take them out to lunch. Call them on the phone. Write to them. Confront them so we can explain medicine's needs and what is best for our patients. Contact your senators and representatives on a regular basis so they know you and have confidence in you. The world is run by those who show up, who participate. If I accomplish nothing more than to get this point across today, it is a beginning toward achieving our goals.

The politicians do listen to MSMS staff lobbyists and your leadership. But they are more likely to act when they get pressure from the grass roots.

Solidify doctor/patient relationship

Another important grass roots activity is to make a sincere effort to solidify the doctor/patient relationship. I know that many of the forces in today's society, especially the malpractice crisis, tend to destroy that traditional relationship. However, I maintain that to get the needed public support for resolution of any of our problems we need an improved doctors' image and that depends upon our relationship with our patients.

Participate in MSMS activities

I am asking each of you here today to recommit yourselves to involvement in all MSMS activity.

MSMS membership comes from many sources. We have specialties: surgeons, orthopedic surgeons, family practitioners, obstetrician/gynecologists, ophthalmologists. We have sections — the Graduates of Foreign Medical Schools, whom I welcome here today at their first House of Delegates as an official section; we have the Young Physicians Section, the Residents Section, the Hospital Medical Staff Section, the Medical Students Section. We are as diverse as the sources of the Muskegon River. Our diversity gives us depth, our unity gives us strength.

The absolute necessity to maintain unity in the profession permeates almost all challenges we face and forms the cornerstone for my presidency and continued leadership in MSMS. We see polarization between primary care and high risk physicians in the malpractice crisis over premium rates; polarization that is most evident in alternative health care delivery systems with the gatekeeper concept. Polarization surfacing in training centers, hospitals and health care corporations competing with private practitioners for patients. Polarization emerging between urban and rural physicians. Polarization between specialists over competitive procedures and different reimbursement schedules for the same procedures. And the coup de grace could take the form of the Resource-Based Relative Value Scale.

How do we deal with the problem of maintaining unity? First of all, let's use the perspective that I constantly refer to: resolve every problem in the light of what is best for quality medical care. But along with that, my colleagues, I implore you; let us be reasonable in all of our reactions. Regardless of our specialty or area of practice, let us:

■ understand each other's position

■ work together to learn the facts

■ be trustworthy and maintain integrity

■ demonstrate that physicians can unify to accomplish good that is in the best interest of the public and is not necessarily self-serving.

I believe we are capable of that kind of unity. The divide and conquer method has worked successfully in other countries and a brand of medical care has developed which would not be palatable to most Americans! This doesn't mean that we won't thoughtfully evaluate the Canadian National Health System...that we won't listen to the argument of the Physicians for a National Health Program...that we won't look at Perry Bullard's Michi-care alternative for our state. But let us, in a united effort, assure quality care for our patients and not let the politicians delude nor hoodwink the public into accepting something inferior. Don't let it happen here! Stay united!

Three major challenges

As I see them, the top three challenges facing MSMS include AIDS, cost containment activities by government and industry, and the medical liability crisis.

First, AIDS is a challenge not only for our profession but for all of society. MSMS is attempting to meet this challenge with an aggressive program which includes most important leadership in the legislative process.

The second major challenge tests the very character and fiber of the profession and that is current cost containment activity. Our governor has commissioned a task force to formulate a recommendation on cost containment. MSMS has taken an active role in these discussions in an attempt to preserve and protect quality of care to the best of our ability in the face of cost containment measures. This will remain a priority for us!

I feel that potentially the most destructive of all challenges is the malpractice crisis. As chairman of the MSMS Task Force on Professional Liability, I can tell you since the resurgence of this problem a few years ago, our society, its membership and friends, have devoted considerable time, effort, and resources toward solving it.

In the past few years we have had some success, most recently with passage of the pension protection bill, a crowning achievement for Fred Bryant's presidency. But an ultimate solution will require an individual rededication to that end. In the last year or so, we at least have been able to keep the issue on the front burner and keep it very much alive.

In dealing with the malpractice crisis we have to look at three goals: (1) Legislative remedies, including alternatives to the tort system; (2) Improved physician licensure and discipline; and (3) Increased risk management activity.

We have set 1990 as the goal to establish a long-term solution to this albatross that hangs around our neck. I don't expect it to be a fait accompli by then, but I hope to see a strong, realistic alternative settlement system being seriously discussed in the legislature by the end of my term.

An MSMS survey indicates that 75 percent of the people of Michigan are willing to accept an alternate method of settling liability claims, if the claims are settled quickly and uniformly and if the system is equally accessible to all. Now we just have to convince the legislature.

For the past year we have been working with several other organizations, collecting information on a variety of alternatives that would cover all the bases.

You might ask — given the legislative and judicial climate that we have in Michigan, plus the influence and power of the attorneys — what realistic chance do we have of instituting an alternative to tort resolution when we are confronted with such issues as right to jury trial, due process, and equal protection?

I'll be candid. It's going to be difficult and expensive. It will require a great deal of time and effort. It is challenging and at times will be discouraging! But for the sake of the citizens of Michigan and our profession, something has to happen! The Governor and the Legislature know this - they realize that access to medical care is threatened - and most of all they fear that the crisis is increasing the cost of medical care in Michigan.

Obviously, the realization of our goals is going to take time. No one sweeping reform is going to solve our problems. But like the river, we must never let up. We must keep pushing, collectively, persistently, always striving for our goals.

Closing comments

My friends and colleagues, our patients and our profession are worth fighting for. Keep the perspective of quality care foremost. Increase your individual involvement in the political arena. Dedicate some of your time to community enrichment. Cement your doctor/patient relationship with understanding and clearly demonstrate a caring attitude.

These are the issues of importance facing organized medicine. I do not underestimate the fight we face, but I will face it with the optimism and hope that comes as naturally to us in the medical profession as it does to every drop of water seeking its natural level. With grass roots participation, with unity, and with realistic and attainable goals, I believe MSMS can move mountains for our profession and for the people of Michigan. ■

HOUSE OF DELEGATES

▪ MEETING HIGHLIGHTS ▪

MICHIGAN STATE MEDIC
VICE SPEAKER
SPEAKER
PRESIDENT
CHAIRMAN
PRESIDENT ELECT

The House of Delegates officially convened with the trooping of the colors. From left on the dais were Richard D. Weber, MSMS legal counsel; Thomas R. Berglund, MD, secretary; Robert D. Allaben, MD, vice speaker; Robert D. Burton, MD, speaker; Fred W. Bryant, MD, president; Frank B. Walker, MD, chairman of the board; and Robert E. Paxton, MD, president-elect.

BOARD OF DIRECTORS

Doctor Walker presented the annual Board report, which focused on professional liability, membership recruitment, communications, physician education, AIDS education, MSMS sections, legislation, Blue Cross Blue Shield of Michigan, MPRO, and MSMS finances.

The House of Delegates made history by approving the first medical society Section for Graduates of Foreign Medical Schools. Elected to the Section Governing Council are (seated from left): Krishna K. Sawhney, MD, vice chairman; Busharat Ahmad, MD, chairman; and (standing from left) Vicente Gracias, MD, secretary; Jose Evangelista, MD, member-at-large; and Samir Yahia, MD, delegate to MSMS. Not pictured are Allan C. D. Brown, MD, alternate delegate to MSMS and Byung Lee, MD, member-at-large.

The pros and cons of all the issues were debated at reference committee hearings Saturday morning, before the close attention of delegates.

The speakers divided the 38 resolutions and two Board reports on medical care delivery between Reference Committees A and AA. The latter committee was chaired by Gary D. Maynard, MD (standing). Committee members included (from left): Robert C. Packer, MD; Bernard J. Kool, MD; and Edward J. Rutkowski, MD.

Reference Committee A members considered half of the many medical care delivery resolutions, which dealt with Medicare provisions, PRO relationships, long-term care insurance, physician representation on the Blue Cross Blue Shield of Michigan Board, and health care cost containment measures.

Michigan Congressman Bill Schuette (R-Sanford) addressed the 1989 Michigan Doctors Political Action Committee luncheon during the House of Delegates meeting.

At receptions during the three-day MSMS annual meeting, physicians receiving honors enjoyed friendly conversation. They included those who have made large contributions to organized medicine; presidents of national medical organizations, presidents of statewide non-medical groups, MSMS past presidents, and the 50-year awardees.

George D. Stilwell, MD, (delegate - Ingham County), closely examined one of the 154 resolutions which confronted delegates at the MSMS meeting.

Michigan Senator John Kelly (D-Grosse Pointe Woods) addressed the 1989 Michigan Doctors Political Action Committee luncheon during the House of Delegates meeting.

Many of the 154 resolutions underwent considerable debate on the House floor. Before voting, Krishna K. Sawhney, MD, (delegate - Wayne County), and other delegates, took time to review their notes.

An invited guest to the MSMS House of Delegates meeting, Joseph Painter, MD, vice chairman, AMA Board, took a moment to bring delegates up-to-date on AMA concerns.

EXAUGURAL ADDRESS

TIME PASSES QUICKLY, Says Fred W. Bryant, MD

Following are excerpts of Doctor Bryant's exaugural address which was given during the MSMS House of Delegates Meeting, May 5, in Dearborn.

Top: Robert D. Burton, MD, (left) MSMS Speaker of the House, congratulates outgoing MSMS President Fred W. Bryant, MD, for his outstanding term in office. Right: Doctor Bryant reflects on his year as MSMS president.

It is just a year since I bid you good marrow on a fine spring afternoon, the dawn of my day in the sun. Now, twilight is upon us and my term comes to an end. Let us see what the year has wrought.

If we look beyond professional liability and reimbursement, issues we cannot control, all's well in medicine's house. Our educational efforts proliferate, these include: (1) The MSMS Annual Scientific Meeting, attended this year by 1,500 individuals who accumulated 8,800 CME hours of credit; (2) The Michigan Conference on Maternal and Perinatal Health, with 600 people enrolled; (3) the MSMS Sports Medicine Conference, with 300 attendees; (4) The AIDS Information Project, which reached 81 organizations and attracted 5,358 attendees.

The Society now has five sections, a family of siblings; Hospital Medical Staff, Young Physicians, Graduates of Foreign Medical Schools, Residents and Students. They can be thought of as a mathematical formula which adds to the Society so that it is greater than the sum of its parts, subtracts nothing, multiplies by dividing, and finds common denominators which enhance the whole. An enviable equation highlighting the uniqueness of each.

The Physician Service Group (PSG), our mercantile arm, has made major advances this year in presentations in education areas, practice management, investing, reimbursement, and retirement. It services 12 specialty societies with 4,000 members, and has handled 13 million dollars in physician health and dental insurance.

Quite remarkable, too, is the quantum leap in media activities. In one year, incoming phone calls have increased from three to four a week to 15 or 20. MSMS costs of clipping service, which reads all periodicals in Michigan and sends us stories, have quadrupled this year, indicating we are a credible source of information. Physician visits to newspaper, radio and TV stations exceeded 50 this year compared to 20 a year ago. Many public service announcements were released. The Society has acquired new desktop equipment which brings more publication production in-house, reducing costs and offering better control. Our MSMS "Production Room" output totaled 2,041,333 "sheets" this year!

A year well spent

For me personally, this has been a year well spent, reaching out, traversing thousands of hours and thousands of miles for the Society. A world of friendships, a few rekindled for the first time over a bridge of four decades, some taking finite form for the first time, known before only through remote reputation or correspondence, and still others nascent and newly formed on the circuit. A time of personal reward and enchantment, free of fatigue, a chance to go forth, to be recognized, and to feel good. It is difficult to be, at once, a common and uncommon man. To be sophisticated and urbane, yet plain and simple. Extroversion versus introversion. There's a delicate balance between humility and egoism. Winston Churchill once remarked that Neville Chamberlain was a modest man, and had much to be modest about. My avarice is that I wanted to see everything and to do everything, my creed that I wanted the best for you. I tried to think, dress and act the part of a President. Not once in the past year did I speak in anger, but always in good humor, and never uttered a professional profanity. Whenever you called, I responded. The respect I hold for you, the Society, is far greater than any of you individually could have for me. Enamored from the start, for me its always been a love affair.

A summary of the year

It is appropriate that I give you a final weather summary of the year. Spring opened spawning and budding new life, with the sugary sap of optimism. Summer's high haze of activity was intense and sultry, a torrid pace, a merry chase. Fall, a time of fruition and the acme of productivity and maturation of gainful employment, the fruits of seeds sown so long ago and industriously cultivated. The winter of our discontent, often wistful and wry, was fairly mild this year. Crisis passed me by - no blue howlers, as they say in Texas.

Time passes quickly: In a way, a year means so little. If we are to change this world at all it will be in small increments.

The siderial swirl of the seasons has gone full cycle and the optimism of spring bubbles up once more. In a sense, I leave you where I found you, on the brink of great things. I hear the voices of the Kennedys' resounding through the '60s, "we can do moa, we can do betta"! ■

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References:
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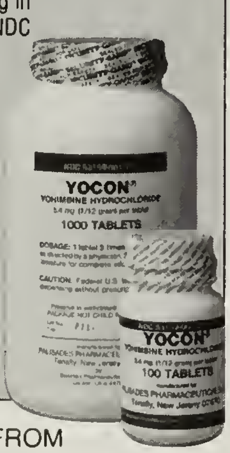

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PRESIDENTIAL PROFILE

"MSMS must continue to dedicate its resources and energies towards reaching a resolution to the professional liability crisis so that physicians can once again practice medicine and stop getting involved in the legal exercises of engagement.

"While professional liability will be the major focus of his presidency, Doctor Paxton says "I realize there are numerous other problems and activities that equally deserve our attention and are priority items of MSMS. I know that I must not only lead, but also reflect all the concerns of the physicians whom I serve."

New MSMS President Robert E. Paxton, MD

By Betty J. McNerney, Managing Editor

Hailing from one of the state's smallest county medical societies — Newaygo County — Robert E. Paxton, MD, assumed years ago that his service as a delegate to MSMS would be the extent of his involvement in organized medicine.

He was wrong.

Doctor Paxton was named chairman of the MSMS House of Delegates Ways and Means Committee in 1979 and has steadily ascended through the MSMS leadership structure since. On May 6, at the MSMS House of Delegates meeting in Dearborn, Doctor Paxton was inaugurated as the 124th president of MSMS.

MSMS involvement extensive

Doctor Paxton served on the MSMS Board of Directors from 1979 until he was chosen president-elect in 1988. During those 10 years he was chairman of the Finance Committee and vice chairman and chairman of the Board. Doctor Paxton currently guides the state society as chairman of the MSMS Task Force on Professional Liability. In addition, he is a delegate to the American Medical Association. He has served for many years on the Board of the Michigan Doctors Political Action Committee (MDPAC), which, he says, "has allowed me to express my commitment to physician involvement in the political process to improve medical care."

Likewise, as Board member and president of the MSMS Health Education Foundation, he fulfills his "altruistic obligation to the underprivileged in health care and education."

As MSMS president, Doctor Paxton says he hopes to accomplish three things:

(1) That "we will see evidence that our unity in the state of Michigan is strong; that we will see more cooperation between the specialties under MSMS' umbrella."

(2) That "we will see evidence of tremendous input from the grass roots, such as letters to the editor, calls to the Society, strong attendance at county medical society meetings, competition for participation in MSMS section meetings, and competition for delegate posts."

(3) That "we are well-organized and on our way to reaching a solution to the professional liability problem. Although I hope that by 1990 we will have a package of changes in the tort system which will include alternatives, I realize that everything cannot be accomplished within one year. I do hope that we will be on our way to gaining momentum, support and political clout; that we will win a few more skirmishes."

Liability a key concern

MSMS must "continue to dedicate its resources and energies towards reaching a resolution (to the professional liability crisis)," says Doctor Paxton, "so that physicians can once again practice medicine and stop getting involved in the legal exercises of engagement."

While professional liability will be the major focus of his presidency, Doctor Paxton says "I realize there are numerous other problems and activities that equally deserve our attention and are priority items of MSMS. I know that I must not only lead, but also reflect all the concerns of the physicians whom I serve."

Equally important as resolving the professional liability problem is encouraging grass roots involvement among MSMS members in MSMS activities, says Doctor Paxton. "I am an individual who is totally opposed to a small group running an organization. I am one who feels that the strength of an organization and the viability of an organization depend on grass roots involvement, dedication and input."

Optimism must reign

Many physicians, particularly young ones, are finding reason to flee the state in light of the liability crisis. Even worse, fewer young people are even choosing to enter the medical profession. This is unfortunate, according to Doctor Paxton, who says that "the medical profession is worth fighting for."

"Whether I am the leader of MSMS, or someone else is, I think it is extremely important that we do not deliver a doom and gloom message about the medical profession. We must inspire our young people, get them involved and try to change things. We all must learn to adapt where necessary so that in the end, we can still do basically the same thing: provide quality health care to the citizens of Michigan. It is possible to practice medicine today; it is a different ballgame and there are different rules. But hey, it's not lost; medicine is still a great profession."

A personal note

A native of Fort Wayne, Indiana, Doctor Paxton obtained his medical degree from the University of Illinois Medical School. Prior to that he served in the Navy and took his pre-medical education at Calvin College in Grand Rapids. He completed a year of internship and an additional year of surgical training at E.W. Sparrow Hospital, Lansing, and has practiced family medicine for 33 years in Fremont.

Doctor Paxton has had a longtime commitment to community theater, has served on various boards of the Fremont Congregational Church, was an avid pilot, sky diver and sailor, and now enjoys golf. He and his wife Georgia enjoy her three children, his son and five daughters and "are generously blessed with 15 grandchildren." ■

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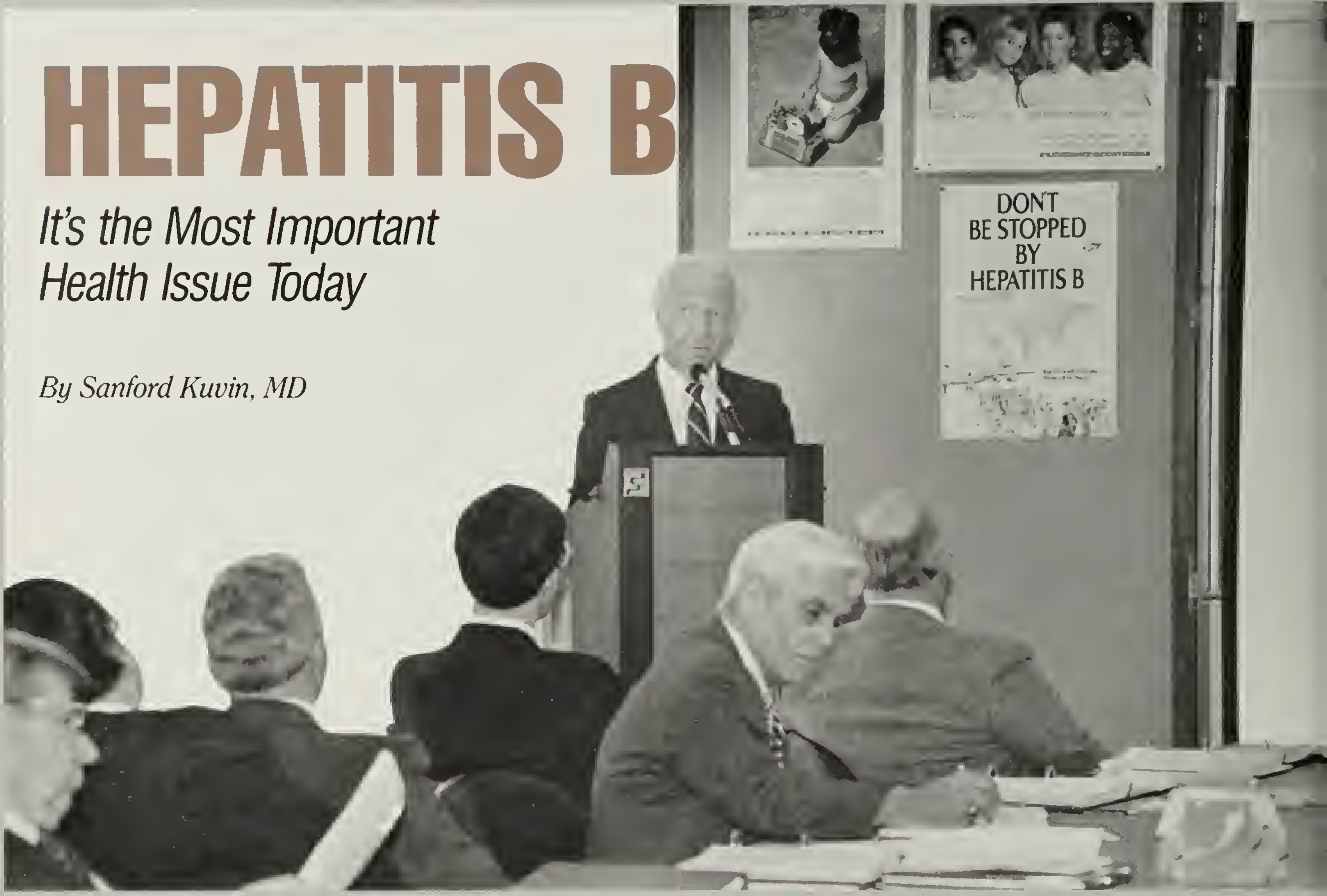
HEPATITIS B

It's the Most Important Health Issue Today

By Sanford Kuvin, MD



Following are excerpts of a speech Doctor Kuvin presented to the MSMS Board of Directors March 8 at MSMS headquarters.

I've come to you today to speak about what I consider to be the most important chronic blood-borne disease in the world. When I say most important, I'm including AIDS. Hepatitis B is regarded by health authorities around the world today as the most important chronic blood-borne virus affecting the health of the world. It is having an extraordinary impact on the American people, and of course, on the residents of this state.

To give you an idea, there are an estimated 10 to 15 million carriers of the AIDS virus in the world today — about one-and-a-half million in the United States. There are over *300 million* carriers of Hepatitis B in the world. In the United States, we have about a million-and-a-half carriers of the Hepatitis B virus.

Too little is known about a disease that a lot of us associate with the word hepatitis. Hepatitis for most of us means Hepatitis A. Hepatitis A, as all of you know, is acquired by eating contaminated shellfish or other contaminated foods. You get a little sick, a little fever, a little jaundice. A few patients become severely ill, but the vast majority of patients get over their hepatitis and go on to lead normal and fruitful lives. With Hepatitis B, the scenario is entirely different.

Hepatitis B causes primary liver cancer. *That's the bottom line.* It also causes acute hepatitis, cirrhosis and chronic globular hepatitis. But the bottom line is that with Hepatitis B, 20 years down the line after you get it, if you are a chronic carrier, you stand a 40 percent chance of dying from primary liver cancer. An additional 15 percent will die of cirrhosis of the liver.

In fact, Hepatitis B, given enough time in the chronic carrier state, is uniformly fatal — just as much as AIDS. But with AIDS, the time span is condensed to maybe 15 years for 100 percent fatality. There are no cures for AIDS; everyone will die given enough time. Hepatitis B also is uniformly fatal given enough time. Most people die of heart disease, other cancers, stroke – but 40 percent of all chronic carriers will get primary liver cancer and die from it.

So, if we say that Hepatitis B is the world's most important chronic viremia, we have to ask ourselves: Isn't it true that the first anti-cancer vaccine ever made is now available and has been available since 1982? Then we have to ask ourselves: Isn't it true that Hepatitis B has crossed the line and is now the most common form of hepatitis in the United States. And, if all these things are true, then isn't it true that we are in front of this virus? Why aren't we doing something about it?

Virus can be prevented

There is total prevention against this virus. There is not only a vaccine with 96 percent effectiveness and genicity, it is the safest and most effective vaccine ever manufactured. If all these things are true, and they are, we have to ask ourselves why it is not being utilized. This vaccine has been available since 1982 in this country, and 1.5 million people have been vaccinated. Who are those people? Ninety percent of the vaccine has gone to one of the least affected groups, a very important group — health care workers.

Ninety percent of the vaccine goes to health care workers, yet only 40 percent of all health care workers have been immunized. That is shocking. It's disgraceful to say that only 20 percent of physicians have been immunized.

That leaves the major targeted groups. And who are the major targeted groups? Intravenous drug abusers are number one (27 percent), followed by sexually active heterosexuals (24 percent), and homosexuals (17) percent. Those are the major groups in addition to the neonates of pregnant woman who are carriers.

There are other targeted groups...like the Alaskan Eskimos, Indians, Asians, parents of adopted Asians, travelers, prisoners, those institutionalized in homes for the mentally retarded.

Millions need vaccine

Thirty million Americans today are in need of the Hepatitis B vaccine and haven't received it. Why has vaccination not been carried out if all this is correct? It's a combination of several things: apathy, ignorance, lack of education, and maybe cost. It's not any one factor; it's a combination of factors. And I must tell you on a personal level that cost should not enter into it. It costs $125 for the series of three shots. I believe that if you were told there is an anti-cancer vaccine available that works, that is safe, you would get it immediately. But it just isn't happening.

When the vaccine first came out many physicians believed there was a tangential relationship to getting AIDS from a vaccine that was derived from blood. This claim was refuted in every scientific publication that existed, yet that myth persists today. And that's nonsense. It just doesn't occur. A million-and-a-half people have been vaccinated in the United States and 30 million vaccinated abroad, and there has not been one significant side effect from the use of this vaccine.

This is probably the most important public health issue facing this state and this nation. This country is incubating a tragedy right now.

I am attached to the National Institutes of Health in an advisory capacity. In a meeting about three months ago, Jim Weingarden, who's the director of MIA, said the good news is that the budget is up to $7.2 billion dollars. But some of you may not be pleased to hear that $1.8 billion is going for AIDS. That means there is a six percent cut in every other form of research. And that is bad news for the health of the American public. In fact, America is falling behind much of the underdeveloped world, never mind the developed world. I was shocked to learn the other day that only 40 percent of the children in this country are getting the full pediatric immunization schedule. These are the facts.

Cases are rising

In 1978, the US had 15,000 cases of Hepatitis B. In 1988, we had 300,000 cases reported. There is a two-to-three factor of non-reported cases. And, let me remind you that hepatitis in its A and B form is the second most common reported disease in the United States after gonorrhea.

About 22 cases of AIDS have been contracted by occupational risk in the health care industry. Last year alone, there were 18,000 such cases of Hepatitis B and 300 died. This should give you a concept of relative importance.

If you are pricked by a needle infected with AIDS, your chances of getting it are less than one-half of one percent. If you are pricked by a needle infected by Hepatitis B, you have a 50 percent chance of getting it. The carrier rate in this country used to be about one percent; it is now up to 10 percent of all those infected. There were 300,000 infected last year. The CDC says that we have 30,000 new carriers coming on board each year. Those numbers are not leveling off, they're going up.

Why? Because Hepatitis B is spread by the same means as is AIDS — sex, blood, needle and birth. It's another sexually transmitted disease, another blood-borne disease, another virus transmitted by the perinatal routing.

Congress is furious with the NIH because our medical intelligence in this country, according to Congress, did not provide us with advance medical warning of AIDS. We knew about AIDS in Africa. They ask why didn't we do something about it when we knew this was happening in Africa. Well, we know what is happening with Hepatitis B and there is no excuse not to implement an extraordinarily aggressive program...Michigan has the opportunity to become a model state.

I was delighted to hear that Michigan, as usual, has taken the lead and has passed a law that provides for obligatory screening of all pregnant women in this state against Hepatitis B. That's as far as the law goes. It also includes HIV testing, unless there is informed refusal. That's a great beginning, but that is only a beginning.

I would urge you to follow through as a model state. Why? For the health of Michigan people. We are falling behind Third World countries. It's terrible.

There are several things this progressive Society (MSMS) has done and can do. The United States looks to middle America and looks to the State of Michigan to do something very positive, because you've always led before.

AIDS has subverted other health issues to a tremendous degree. The fallout on the good side of AIDS is that it has put in place programs which can easily be attached with Hepatitis B at minimal cost. But you'll need legislative help, you'll need the state legislature to become informed, just as much as you need to inform the guys who are practicing medicine on a daily basis as to the implications of this terribly serious disease. ■

Doctor Kuvin is vice chairman, National Foundation for Infectious Diseases, Washington, DC.

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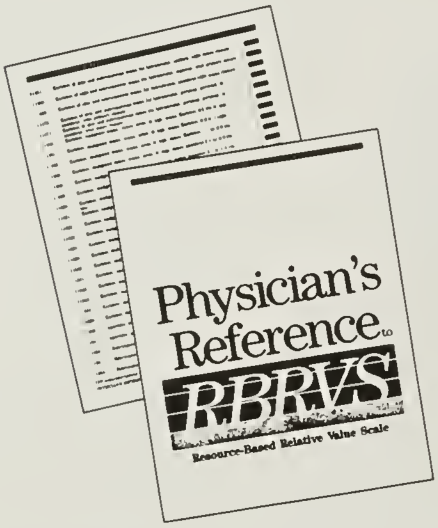
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Dr. Holwick outside of hospital where she practices as a civilian traumatologist.

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JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.; University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital; Huntington Memorial Hospital, Pasadena, California; Traumatologist, Arcadia Methodist Hospital, Arcadia, California.

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Brief Summary

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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Additional information available to the profession on request.

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[1] Data on file, Lilly Research Laboratories.

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Child Day-Care Programs

A MUST, *Says MSMS Committee on Concerns of Women Physicians*

By Chad B. Munger

The MSMS Committee on Concerns of Women Physicians is troubled by the lack of adequate child care available to women in the workplace and is committed to promoting possible solutions to the problem. In the process of studying the issue, the Committee recently found two hospitals in Michigan which have successfully established child care programs for their employees and medical staff. The following article describes, in detail, how each of these hospitals satisfies the need for on-site child care.

A look at the problem

Access to child care is vitally important to health care workers, both as parents and as professionals, and it is no less important to the health care industry itself. Hospitals, in particular, must continually struggle to provide a positive and healthy working environment if they are to maintain their work force. For the working parent, child care is one particularly important feature of that environment.

Most hospitals face a transitory and often understaffed work force, especially in the nursing ranks," says Dawn E. Springer, MD, chairman, MSMS Committee on Concerns of Women Physicians. "Thus, they need to recognize the demand for child care and use it as a tool to forge a happier, more stable relationship with employees."

The ability to provide structured, productive time for children, often on-site with the working parent, has proven to be an excellent way to boost employee morale and efficiency, says Doctor Springer.

For hospitals like Ingham Medical Center in Lansing and Chelsea Community Hospital in Chelsea, offering child care as an employee benefit has become an excellent way of recruiting and retaining staff.

Ingham Medical Center

Ingham Medical Center began offering child care as an employee benefit seven years ago. The program was created to satisfy a growing demand for access to some reasonable form of child care and, at least in part, to attract new staff. A six-month waiting list for new participants and a brand new on-site facility are a testament to the popularity and success of the center.

Ingham's program has the staff and facilities to support 72 children six weeks to five years of age. Three buildings immediately adjacent to Ingham Medical Center make up the center. Two of the buildings are renovated homes; the third is an entirely new building which was constructed after Ingham's auxiliary donated two years of its budget — approximately $200,000 — to build it.

Eighteen people make up the center's staff, all of which have at least a high school education. In fact, the center has had little trouble recruiting more experienced employees. Most staff members have, or are working on, associate degrees in child development.

Continued on page 36

Continued from previous page

The 72 children are split, by age, into eight different classrooms, each having its own teacher and a teaching assistant. The classrooms concentrate on developing social and emotional skills as well as more traditional academic themes.

All children in the program are offspring of hospital employees (physicians at Ingham are not hospital employees and their children are not eligible, except for some resident physicians) and male and female employees taking advantage of the program benefit almost equally.

The demand for services comes mostly during the day when spouses of hospital employees also are working. However, night-shift workers sometimes take advantage of the center's 6:30 a.m. to 6:00 p.m. hours, which allow them time alone during daylight hours when they might ordinarily sacrifice sleep to entertain their children.

The child care benefit at Ingham is subsidized by the hospital, which provides roughly 20 percent of the center's operating costs, while tuition fees supply the remaining 80 percent. Ingham employees may use direct payroll deduction to pay for the service. The center's tuition is a sliding scale based on the age of the child.

Ingham's child care staff concentrates on giving quality care, a fact reflected in the program's accreditation by the National Education Association for Young Children. The center is licensed by the State of Michigan and monitored by the Department of Social Services — even though it does not receive any public funding.

The high quality of care is one of the reasons the program has been so successful in achieving the goals of its founders. "As a recruiting tool, the program has been a real benefit," says Judy Goth-Owens, director of the center. The program also has resulted in lower turnover among employees who have participated in the program. Length of employment has risen by almost three years for those employees, according to Goth-Owens.

Chelsea Community Hospital

At Chelsea Community Hospital a similar child care program enjoys a good deal of its own success. Established in April of 1977, Chelsea's program, like Ingham's, was created in reaction to employee demand and for the now obvious benefits associated with providing this service.

The Chelsea program is designed to accommodate children from preschool through early grade school age. Slightly larger than Ingham's center, the Chelsea program can accommodate 85 children. Hospital employees enroll their children first and spaces left unfilled are made available to the public, a situation which physicians are often happy to take advantage of. The program, which is accredited by the National Academy for Early Childhood Programs, has grown quite popular within the surrounding community which fills roughly one-third of the center's available spaces.

The hospital subsidizes the program for employees: infants and toddlers are underwritten at one-half of the total cost of attendance, preschool and school-age children are underwritten at one third of the total cost.

Non-hospital employees are charged a weekly fee which varies by the age of the child. Rates for school-age children are adjusted on a weekly basis according to the actual amount of time they need care.

Unlike Ingham Medical, Chelsea's program is not located on-site. Instead, Chelsea rents space from local churches.

Kathy Young, director, says that although the program is not run on-site, it is close enough for hospital employees to visit during the day, and many of them do.

Children in the program are segregated by age, with each of the three levels of that division supervised by members of the program's 18-member staff. Employment standards set by Chelsea Hospital apply to workers at the center. Many of the staff hold college degrees in fields related to child care. The preschool and school-age program directors are both degreed teachers, and many of the aides are continuing their education at local colleges. All staff are employees of the hospital which considers the program to be a department of the hospital itself.

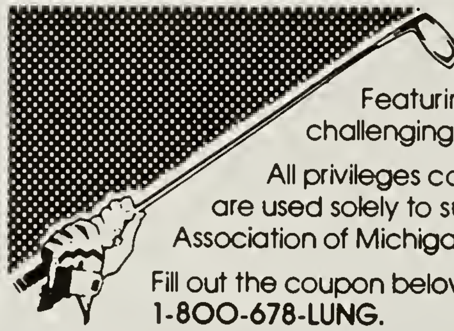
"Our main focus, rather than academic, is helping the children progress emotionally and socially in their respective developmental stages," says Young. "The preschool program, in the morning, is very similar to what you would expect to find in a nursery school. In the afternoon, the atmosphere is much more relaxed," she adds.

With curricula in place for each level of the program, the center offers a constructive consistent experience. Yet flexibility, adds Ms. Young, is always a goal of the program.

Hospitals take the lead

The flexibility to meet the needs of health care workers as employees and parents is a quality both Ingham Medical Center and Chelsea Hospital have exhibited. By recognizing the difficulties of simultaneously raising children and trying to be an effective health care worker, both hospitals have moved toward the goal of a more efficient and stable health care system. By initiating employee child care programs, both institutions have become leaders in improving the quality of the health care environment for everyone. ■

Chad Munger is an East Lansing-based freelance writer.



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Understanding the Power of EFFECTIVE COMMUNICATIONS

By Peter Marabell
and Larry W. Fitzsimmons, MD

Medical professionals must anticipate and meet the challenges of a rapidly changing society. In an age of information — some would say information overload — only those professionals who recognize and understand the value of the communication process will be equipped to meet those challenges and "practice the art of the profession."

Professional liability

In the last 20 years, two dynamic issues have invaded the serenity of the physician's office: professional liability and the need to market services. Each issue is complex, poorly understood, and all too often threatening to the very people who must try to cope with their staggering impact on the delivery of health services. For professionals, effective communication is at the heart of understanding and resolving these difficult issues as the practice of medicine wends its way into the Twenty-first Century.

Professional liability reached crisis proportions in the early 1970s. It spread to other professions during the intervening years, and there is no let-up in sight. Although problems never become crises unless a number of factors merge, it is clear that misunderstanding — result of poor communication — is the most significant factor contributing to the liability dilemma faced by medical professionals today. Misunderstanding leads to anxiety for both doctor and patient, who may be decidedly less inclined to follow recommended courses of action. At its worst, misunderstanding leads to serious doubts regarding the competence of professionals. Unfortunately, it also leads to malpractice lawsuits.

Enhanced communication techniques, in addition to careful, thoughtful listening and talking between physician and patient, results in better, clearer understanding of the matters at hand. A better assessment and a more clearly defined course of action often decrease anxiety. Since the expectations of doctor and patient are both more reasonable and more realistic, it is less likely that frustration and hostility will develop. As patient confidence increases, so does the willingness of the patient to follow the recommended course of action. The net effect will be fewer malpractice suits and a growing climate of confidence rather than suspicion.

Marketing/advertising

Compared with liability, the need to market services might seem like nothing more than a simple matter of deciding whether or not to advertise. Recently however, medicine has been subjected to numerous market pressures quite familiar in the business world, but not at all familiar to physicians, dentists, or lawyers. That familiar phrase, "supply and demand," now applies to professional women and men as well. In an earlier time, no one gave very much thought to the number of physicians or their location and there were few, if any, regulations of medical services as familiar to today's practicing physician.

Today, as consumer (patient) demand increases, professionals have begun to realize that simply hanging out a shingle, as it were, is not enough to attract prospective patients in a society that takes the advertising of services, as well as products, for granted. At the same time, those prospective patients, like their product-using cohorts, are infinitely more knowledgeable than their predecessors a generation ago. Patients take at least as much time and effort to learn about their medical care needs and what is available to meet those needs as they do about their consumer purchases. In that kind of arena, it is sound judgment, medically and financially, for physicians to contribute to the education of their prospective patients by describing the services they offer to the residents of a particular community. Again, as with the liability issue, effective use of contemporary communication techniques is the key.

Taking advantage of the public's interest in acquiring more information and its easy access to that information makes good business sense. Professional associations, however, have traditionally restricted or banned the use of advertising as inconsistent with the dignity of professionals. In today's media-oriented society, marketing a physician's professional practice no longer takes on the negative connotations of the past. Still many barriers are embedded in tradition and change has, at best, proceeded at a moderate pace.

Recently, however, the Federal Trade Commission conducted a vigorous review of advertising restrictions in conjunction with legal and medical associations. The net effect was a considerable modification of the ethical restrictions. The American Medical Association, for one, responded to the FTC's ruling that its guidelines on advertising were "unduly restrictive." Through its Council on Ethical and Judicial Affairs, the AMA modified its stand in December 1988, to allow advertising "providing that the communication shall not be misleading." It is the responsibility of physicians to "determine in advance-...that the message is implicitly and explicitly truthful (and) non-deceptive."

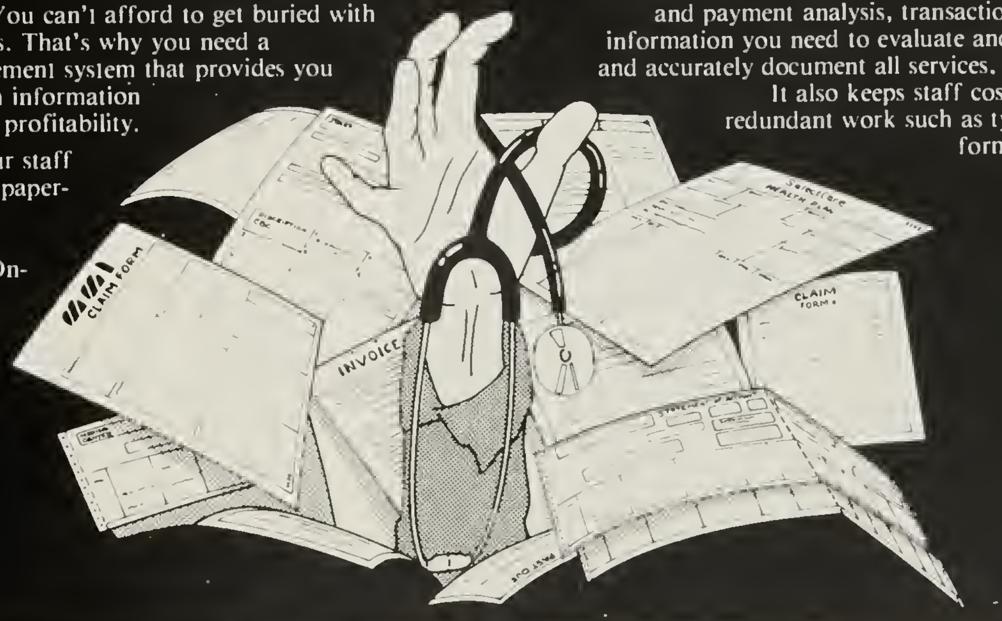
It is an admirable standard, to be sure, but one not easily met. The AMA's opinion underscored the importance and necessity of understanding the communication process. It did not define "communication," or "misleading," or "non-deceptive." When the opinion suggested that "a physician should...communicate...in a readily comprehensible manner," what does that really mean? Physicians are neither trained nor equipped to become media professionals. Some standardization of terms, some understanding of how the communication process fits in, can lead to a general framework within which physicians can reasonably be expected to operate. If there is too much confusion concerning how physicians are to respond, advertising in the health care industry might be no different than advertising soaps, cereals, and automobiles.

The new freedom to describe publicly the services they offer places a burden squarely on the physicians' shoulders to comprehend the communication process. That burden includes identifying the information to be conveyed, designing a method of conveyance, and making certain that the information is "truthful (and) non-deceptive."

It seems clear that the new requirements for marketing will produce a whole new area for the development of communication services. Special innovative techniques and products will be needed. It remains to be seen if medical professionals will have the time and expertise to meet this challenge alone. It may be that like other professionals in today's information economy, physicians and medical specialists will join forces to address the complex needs of the health care industry.

Professional liability and the need to market services are only two of the complex issues challenging medical professionals today. The key to finding workable solutions is understanding the communication process. Only those professionals who recognize the value of effective communication will be equipped to meet those challenges and move forward to "practice the art of the profession" in the years ahead. ■

Peter Marabell, a Michigan State University professor, is a freelance writer and is general manager of GPM Communications, East Lansing. Doctor Fitzsimmons is a Lansing orthopedic physician and is a member of MSMS.



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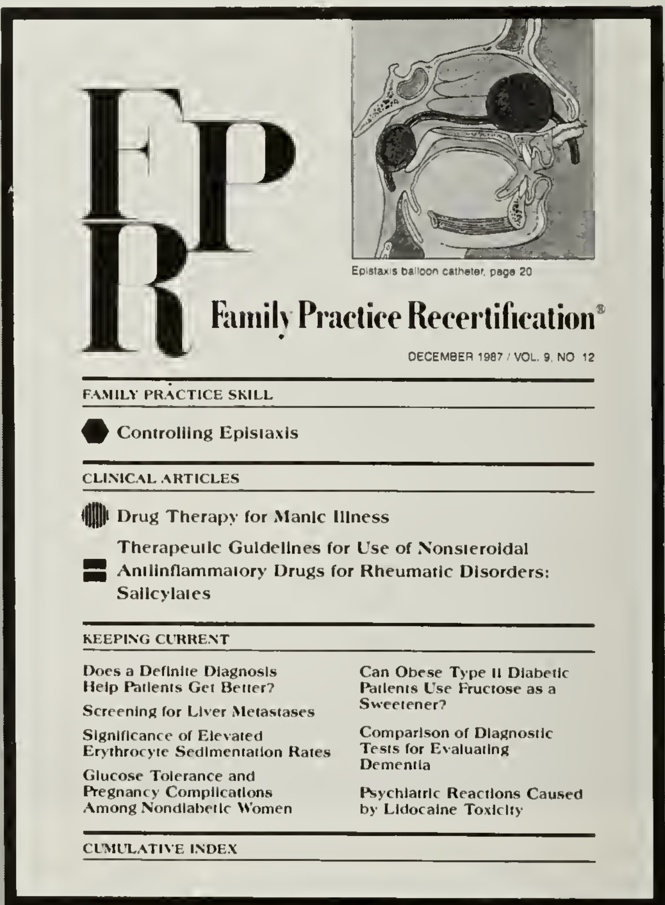

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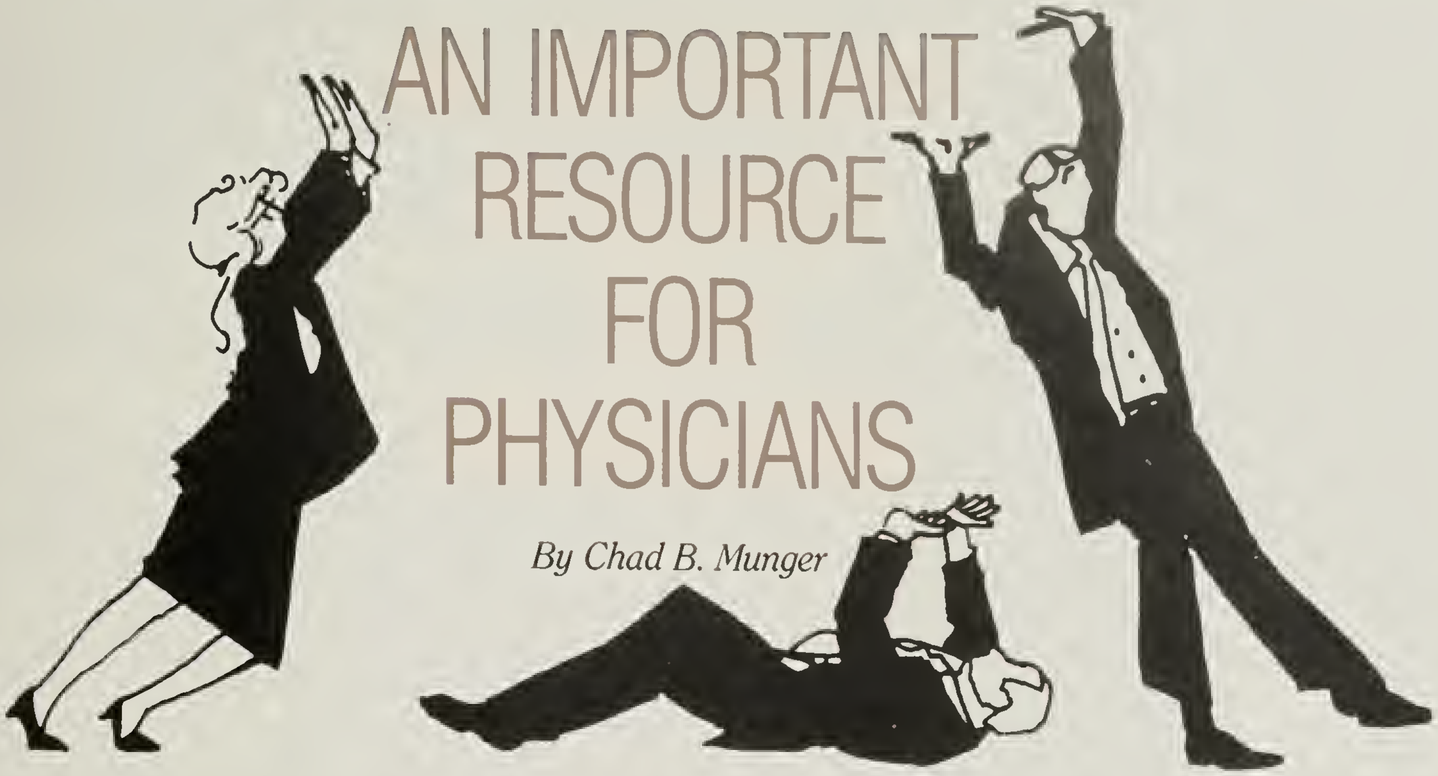

By Chad B. Munger

From the front desk to the examining room, managing patient care is a task that requires the knowledge and commitment of many people beyond the attending physician. Members of the Michigan Society of Medical Assistants (MSMA), committed to improving the quality of patient care, are among these people.

Breadth of skill and knowledge are what make medical assistants uniquely valuable in physician office settings, according to Meridee Czop, CMA-AC, MSMA president. "Medical assistants are multi-skilled health care professionals, trained to do both administrative and clinical work for physicians." she says. "Because we are multi-skilled, we have versatility in the office that other health care professionals do not. Medical assistants can rotate from the front office to the back office; whereas a nurse may not be able to work the front office and a secretary cannot work in the back."

For medical assistants, keeping up with developments in their professional lives means doing double duty. For this purpose, the MSMA is an important resource. The MSMA is a tri-level organization, consisting of national, state and local chapters. Forty-five board members are appointed by the current MSMA president for one-year terms which begin in April. Candidates are selected from the state's general membership.

MSMA, whose primary function is "to provide continuing medical education to medical assistants," is one of the nation's strongest state-level organizations. Its more than 1,000 members represent workers in a variety of health care professions including medical technicians, nurses, medical secretaries and transcriptionists. MSMA members account for more than 10 percent of the total membership of the national association.

Four annual seminars are the primary tool used to deliver continuing education to MSMA members. Local chapters sponsor these seminars at locations around the state. Seminars dealing with clinical and administrative issues such as third party reimbursement, Medicare participation, and fostering positive physician/patient relations, are typical of the kinds of education MSMA provides to its members. All seminars are designed to provide the most advanced information possible. Participants are eligible for Continuing Education Units (CEU).

Certification is another focus of MSMA, according to Ms. Czop. "MSMA has the highest percentage of certified Medical Assistant members in the nation," she says. Continuing education becomes especially important in light of the fact that re-certification is required every five years. Re-certification can be accomplished either by retaking the certification exam, the more popular option, or by obtaining CEUs.

Strong physician support

MSMA and its educational objectives have found a good deal of support from Michigan physicians. At the local level, support depends greatly upon the organization of both the local MSMA chapter and local medical societies. A number of chapters do enjoy strong ties with their county medical societies.

On a state level, MSMA enjoys a strong and expanding relationship with the Michigan State Medical Society. The medical assistants' emphasis on education and their obvious interest in improving health care in Michigan are consistent with the goals of MSMS and have resulted in a positive working relationship. MSMS not only provides financial support to MSMA, but also substantial administrative support. MSMS provides the services of Caroline Kimmel, an account executive to MSMA. "Caroline is responsible for producing our delegates package — a huge job," says Ms. Czop. In addition she handles correspondence for MSMA which uses the medical society's address as a state mailing address.

MSMA continues to seek the recognition and support of physicians and other health care workers around the state. The association believes that its educational programs work for everyone. Evidence of this may be found in the fact that MSMA members consistently score higher on certification exams than non-members.

Test scores aside, the greatest asset MSMA members bring with them to a physician's office is commitment. "I think that MSMA members are more dedicated and involved than any non-members," says Ms. Czop. "Their membership is a commitment to keeping abreast of what's going on in the field."

For more information on MSMA, contact Caroline Kimmel at (517) 337-1351. ■

Chad B. Munger is an East Lansing-based freelance writer.

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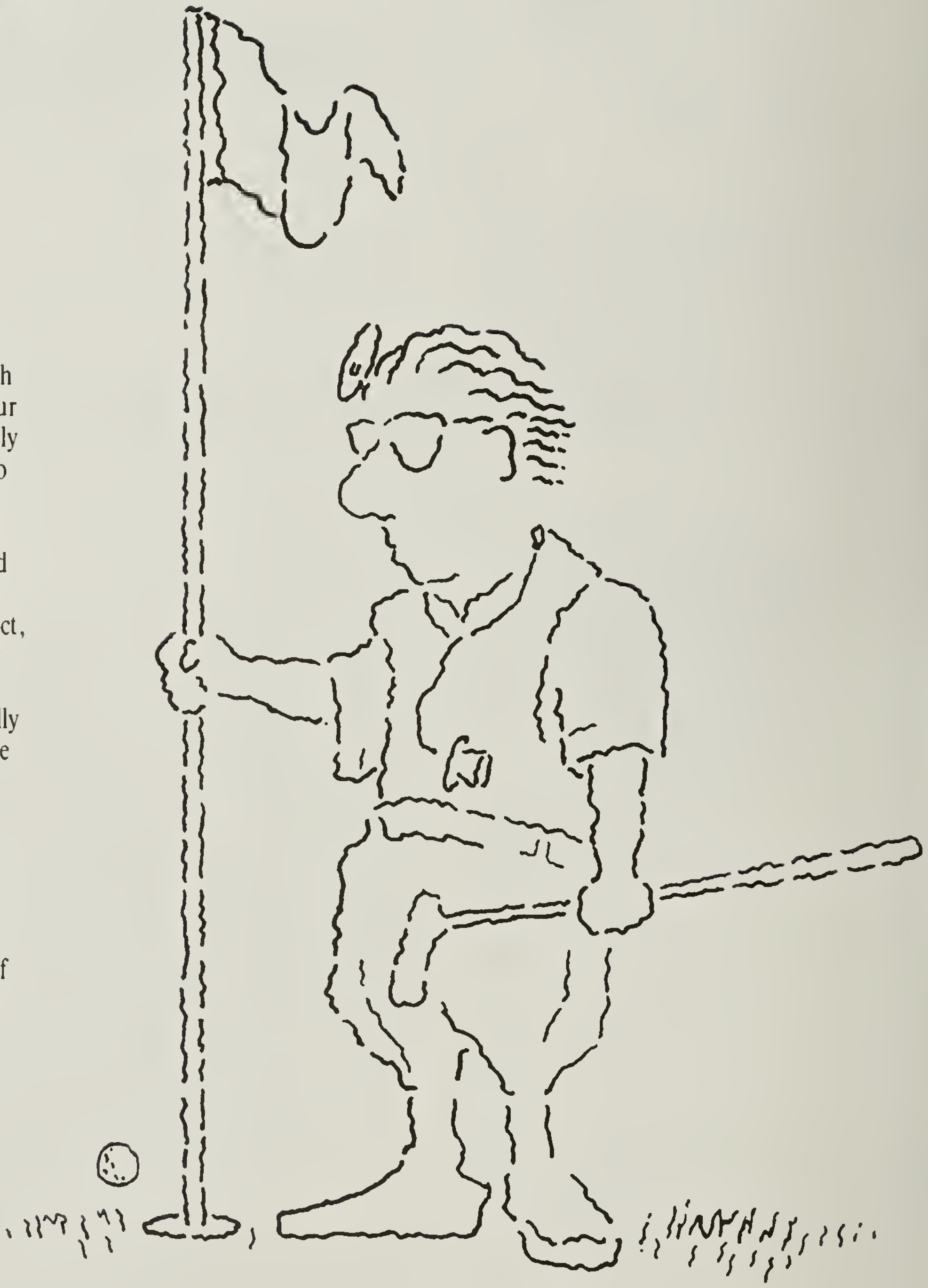

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10

DEATHS

Byron Casey, MD
Lansing

Byron Casey, MD, a retired Lansing area psychiatrist, died April 11. He was 70. Doctor Casey received his medical degree from the University of Chicago in 1943. He served in the US Army in Europe during World War II and rose to the rank of Major before he was discharged in 1946. He then began his private practice in Detroit and later moved to Lansing. Doctor Casey was a member of the American Psychiatric Association, American Association for Advancement of Science, Michigan State Medical Society, and Ingham County Medical Society.

James E. Coyle, MD
Grosse Pointe

James E. Coyle, MD, a Detroit ear, nose, and throat specialist, died April 23. He was 68. Doctor Coyle received his medical degree at the University of Michigan in 1945. He served as director of the Otorhinolaryngology Department, St. John Hospital, Detroit, for 20 years until 1972. Doctor Coyle was a member of the staff at Bon Secours Hospital. He was a member of the Detroit Country Club, Wayne County Medical Society, Michigan State Medical Society, American College of Surgeons, and the American Academy of Otolaryngology and Ophthalmology.

James R. Duncan, MD
Detroit

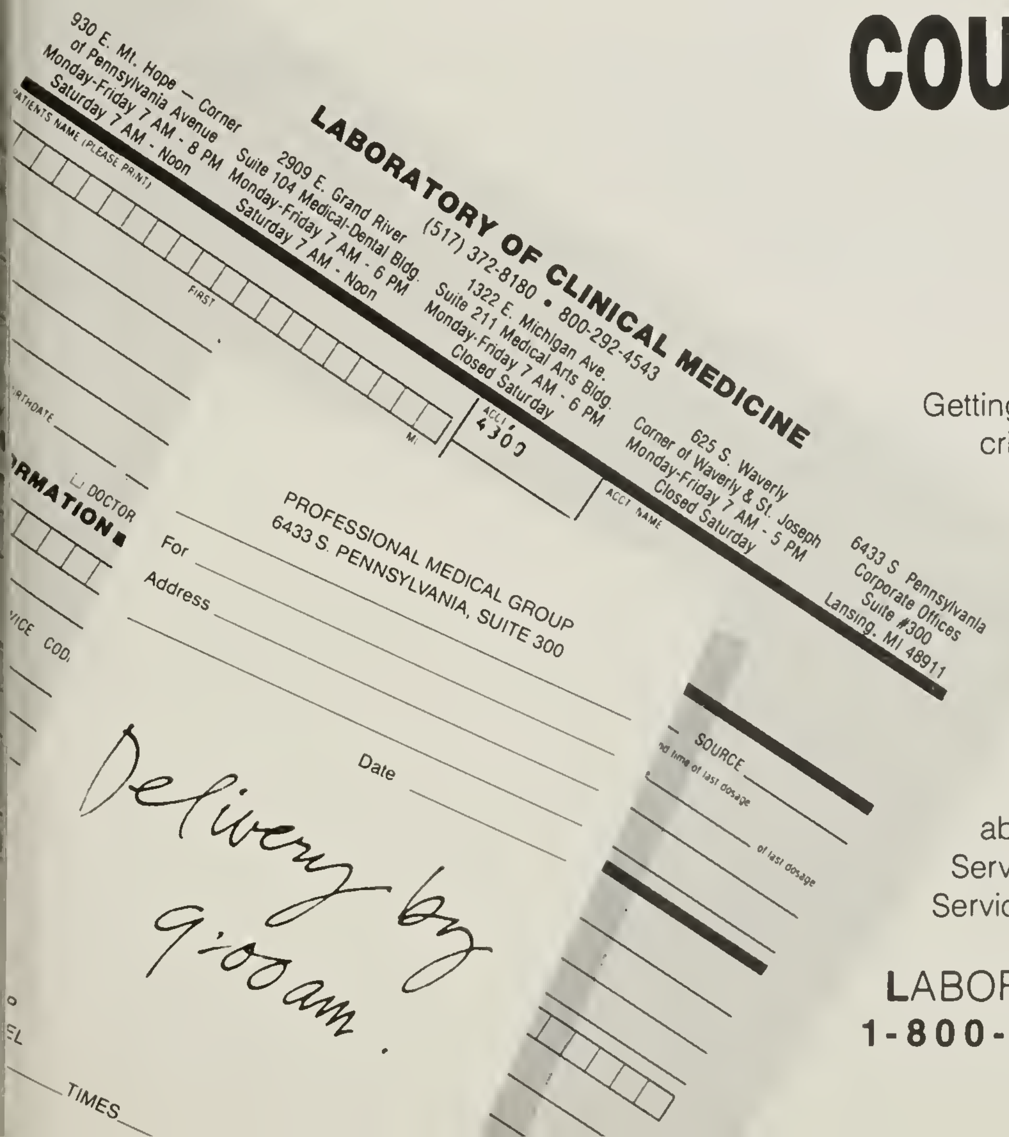
James R. Duncan, MD, retired medical director of Detroit Medical Plaza, died April 14. He was 70. Formerly a director of the Detroit Fire Department - medical division, Doctor Duncan was a graduate of Meharry Medical College. He was a member of the NAACP, the Wayne County Medical Society, the Michigan State Medical Society, and the American Society of Family Medicine.

William Maliszewski, MD
Warren

William M.B. Maliszewski, MD, a Warren area physician, died March 29 at the age of 39. Doctor Maliszewski graduated from Wayne State University Medical School in 1977 and completed his residency training in pediatrics at St. John Hospital, Detroit, and the Detroit Medical Center. One of his main interests was working with handicapped children. He was director of handicapped children at St. John Medical Center and a board member, Foundation for Exceptional Children, Grosse Pointe. Doctor Maliszewski was a member of the American Society of Human Genetics, American Academy of Pediatrics, American Medical Society, Wayne State University School of Medicine Alumni Association, Notre Dame Alumni Association, and the National Monogram Club at Notre Dame.

Henry Van Duine, MD
Grand Rapids

Henry Van Duine, MD, former chief of surgery, Saint Mary's Hospital, died April 16. He was 85. Doctor Van Duine graduated from Hope College in 1926 and the University of Michigan in 1930. He served his internship at Henry Ford Hospital, Detroit, and then spent 12 years at the Byron Center as the country physician. Doctor Van Duine opened a private practice in his home for four years then moved on to join the staff at Saint Mary's. He was active in the American Board of Surgery, International College of Surgeons, Association of Atomic Scientists, American Association of Geriatrics, and the American Association of Gastroenterology.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1989 MSMS TOP ISSUES

MSMS has a plan of action for 1989 emphasizing its top issues. The Board has approved the plan, as introduced by MSMS President Fred W. Bryant, MD. "We are gearing for a high-energy year," said Doctor Bryant. Though professional liability leads the list, the other items are of key importance, also. They are:

1. Professional Liability:	MSMS is lobbying for protection of pension and profit-sharing plans in the event of bankruptcy proceedings. Speaker-elect Lewis Dodak has promised that pension protection legislation will be a priority in the 1989 session. MSMS also is exploring non-tort alternatives such as: — An at-fault system which would pay compensible claims similar to workers' compensation payments. MSMS is joined in this effort by the Michigan Hospital Association. — A program similar to the Swedish patient compensation, risk management and physician discipline systems. — Either mandatory arbitration or reduced health insurance premiums for physicians using the Michigan arbitration system. — A "bad baby" fund similar to the recently-enacted Virginia plan which helps compensate for birth-related injuries regardless of cause. MSMS is reviewing the plan as part of a demonstration project for the Health Policy Agenda for the American People. — MSMS will continue to seek tort reform, pressing for removal of the exceptions to the cap on non-economic damages, further improvement in the statute of limitations, stricter qualifications for expert witnesses, evaluation of the modification of the joint and several rule, and countersuit legislation.
2. Integrated Licensure:	MSMS will lead in developing a new physician discipline structure similar to that of the State Bar.
3. Risk Management:	MSMS will inform Michigan physicians of how to minimize risks of lawsuits and how to take advantage of premium reductions for attending risk management seminars.
4. AIDS:	MSMS and the State Bar are developing a series of policy statements to protect physicians in management of AIDS patients. The policies will go to the legislature in early January. MSMS also leads in AIDS provider education efforts through a Michigan Department of Public Health grant.
5. Quality Health Care:	MSMS will continue to emphasize quality health care in the face of cost containment, in dealings with the new Governor's Task Force on Managing Health Care Costs, and in a joint effort with the Michigan Health Data Corporation and Michigan Hospital Association to develop a quality institute.
6. Physician Education:	MSMS will continue to provide continuing medical education, updates on preserving quality of care and on improving practice productivity.
7. Hospital Medical Staffs:	MSMS leaders will work to address nearly 20 hospital medical staffs at their general meetings in 1989. This will continue the "Physicians' Issue Presentations" initiated in 1988 which complement activities of the MSMS Hospital Medical Staff Section.
8. Third Party Payers:	MSMS will continue its advocacy efforts on behalf of Michigan physicians with Blue Cross Blue Shield of Michigan, Medicaid, Medicare, and MPRO.
9. RBRVS:	MSMS will serve as convenor for discussions with the 34 recognized Michigan specialty societies, to discuss the Harvard Resource-Based Relative Value Scale (RBRVS). MSMS also will propose four informational forums with RBRVS experts.
10. Physician Recovery Network:	MSMS is seeking legislation which would create a joint MSMS/Board of Medicine program to divert physicians into treatment and grant them immunity while working in the program. MSMS is actively pursuing alternative funding for the Network sponsored by MSMS and MAOPS.
11. Elder Care:	MSMS will establish liaison with the Michigan Office of Services to the Aging and the Michigan Chapter, AARP.
2. Media & Public Relations:	MSMS will increase efforts to serve as a reliable source of information to the public and media.
3. Non-dues Income:	MSMS will continue to improve its financial soundness by enhancing non-dues income. Hagadorn, Inc., a joint venture with MPMLC, is expected to provide a longterm real estate investment to enhance revenues. Physician Service Group, Inc., and the Peer Review Organization of Michigan, wholly-owned subsidiaries of MSMS, continue to increase non-dues revenues.
4. As Always:	MSMS will continue to emphasize county society activities, member communications, recruitment, benefits and political activity. As always, the goal of all MSMS activities is to ensure the availability of, and access to, quality medical care for the people of Michigan.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Ishpeming 49849

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Continued on page 50

NEW MEMBERS

Continued from previous page

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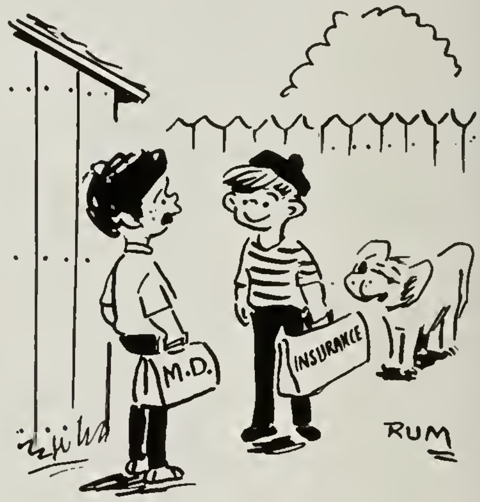

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

July

19, Risk Management Seminar. Location: Ramada Inn, Marquette, Michigan. **Sponsor:** Michigan State Medical Society, Michigan Physicians Mutual Liability Company. **Contact:** Jeanne Miller, Departmental Secretary, 120 W. Saginaw St., P. O. Box 950, East Lansing, MI 48826-0950. (517) 337-1351.

20-21, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Munson Medical Center, Traverse City. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386 (616) 922-9546. **Approved for:** 9-13 hours Category I Credit.

23-26, 3rd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (31) 763-1400. **Approved for:** 13 hours Category I Credit.

27, Risk Management Seminar. Location: Bay Valley, Bay City, Michigan. **Sponsor:** Michigan State Medical Society, Michigan Physicians Mutual Liability Company. **Contact:** Jeanne Miller, Departmental Secretary, 120 W. Saginaw St., P. O. Box 950, East Lansing, MI 48826-0950. (517) 337-1351. **Approved for:** 4 hours Category I Credit.

August

4-5, Endoscopic Sinus Surgery. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Debra DeSmyther, Program Assitant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 15 hours Category I Credit.

6-9, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Internal Medicine. **Contact:** Gayle Fox, Program Assitant, Office of Continuing Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 10 hours Category I Credit.

7-9, Airborne Pollen and Fungus Spore Identification: A Hands-On Workshop. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 17 hours Category I Credit.

9, Risk Management Seminar. Location: Wayne County Medical Society, Detroit, Michigan. **Sponsor:** Michigan State Medical Society, Michigan Physicians Mutual Liability Company. **Contact:** Jeanne Miller, Departmental Secretary, 120 W. Saginaw St., P. O. Box 950, East Lansing, MI 48826-0950. (517) 337-1351. **Approved for:** 10 hours Category I Credit.

18-21, Cardiology Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 10 hours Category I Credit.

24-26, Contemporary Issues in Obstetrics and Gynecology. Location: Grand Traverse Resort Village, Grand Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

25-27, Endocrinology and Diabetes Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 7 hours Category I Credit.

25-28, 15th Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

September

7-8, The Practice of Clinical Nutrition: Science & Application for the Future. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School Parenteral and Enteral Nutrition Team and Department of Surgery. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 10 hours Category I Credit.

11-12, Epilepsy Advances. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Neurology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, Michigan 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

14-16, Recent Trends in Clinical Electrophysiology: Intraoperative Monitoring. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

21-23, The National Conference on Pediatric Trauma. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** Kiqanis Pediatric Trauma Institute, New England Medical Center, University of Mchigan Medical School, General Motors Corporation. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 20 hours Category I Credit.

21-24, **34th Annual ACP-Michigan Chapter/MSIM Regional Meeting. Location:** Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** American College of Physicians, Michigan Chapter and the Michigan Society of Internal Medicine. **Contact:** Patrick C. Alguire, MD, FACP, Department of Medicine, Michigan State University, B-301 Clinical Center, East Lansing, MI 48824. (517) 353-5100. **Approved for:** 18.5 hours Category I Credit.

October

2-3, **Update on Pulmonary and Critical Care Medicine. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

4-6, **A Symposium on Neonatal Respiratory Disorders. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. **Contact:** Betty Phillips, Ptrogram Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Ctegory I Credit.

5-7, **12th Annual Seminar in Diagnostic Ultrasound. Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debra DeSmyther, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201 (313) 763-1400. **Approved for:** 16 hours Category I Credit.

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MSMS Meetings

July

13-15, MSMS Board of Directors Mid-Summer Meeting, Shanty Creek, Bellaire, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

September

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, Michigan, Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

26, MSMS Public Affairs/Leadership Conference, Lansing Radisson, Lansing, Michigan, Contact: Mary Anne Ford, MSMS Chief, State Government Affairs, (517) 337-1351.

28, 1989 CME Conference, Hilton Inn, Lansing, Michigan, Contact: Katie Brewbaker, MSMS Chief, Support Services, (517) 337-1351.

AMA Meetings

June

18-22, AMA House of Delegates Annual Meeting, Chicago Hilton, Chicago, Illinois, Contact: AMA, 535 North Dearborn Street, Chicago, IL 60610 (312) 645-5000.

October

2-3, Eighth Annual AMA Science Reporters Conference, Marriott Medical Center Hotel, Houston, Texas, Contact: Bill Silberg, AMA, 535 North Dearborn Street, Chicago, IL 60610. (312) 645-4417.

Michigan Specialty Society Meetings

June

17-18, Michigan Association Neurological Surgeons Meeting, The Homestead in Glen Arbor, MI. Contact: Hugo Lopez-Negrete, MD, G-3239 Beecher Rd., Flint, MI 48532. (313) 733-7560.

22-24, Michigan Orthopaedic Society Annual Meeting, Boyne Highlands, Contact: Arthur Manoli, II, MD, Orthopaedic Surgery, Hutzel Hospital, 4707 St. Antoine, Detroit, MI 48201. (313) 745-6955.

22-25, Michigan Otolaryngologic Society, Annual Statewide Meeting, Contact: Karen Turner, Wayne County Medical Society, 1010 Antietam Road, Detroit, MI 48207. (313) 567-1640.

July

10-12, Sixteenth Michigan Emergency Medicine Assembly/Annual Meeting, Grand Hotel, Mackinac Island, Contact: Kathryn Hopkins, 500 Lansing Road, Charlotte, MI 48813. (517) 645-8050.

31-8/2, Michigan Academy of Family Physicians, 43rd Annual Scientific Assembly, Grand Traverse Resort, Acme, Contact: Julie Nelson, 109 East Oakland, Lansing, MI 48906. (517) 482-7410.

November

11, Michigan Psychoanalytic Society, Annual Symposium on "How Therapy Works: A Contemporary Perspective," Hyatt Regency Hotel, Dearborn, Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633.

National Specialty Society Meetings

September

10-13, Society of Thoracic Surgeons, Annual Meeting, Convention Center, Baltimore, MD, Contact: Society of Thoracic Surgeons, 111 E. Wacker Drive, Suite 600, Chicago, IL 60601. (312) 644- 6610.

10-14, American College of Radiology, Annual Meeting, Westin Hotel, Seattle, WA, Contact: American College of Radiology, 1891 Preston White Drive, Reston, VA 22091. (703) 648-8900.

11-14, American College of Emergency Physicians, Annual Scientific Meeting, Grand Hyatt Washington, Washington, DC, Contact; American College of Emergency Physicians, P. O. Box 619911, Dallas, TX 75261-9911 (214) 550-0911.

16-21, American Academy of Family Physicians Annual Scientific Meeting, Westin Bonaventure, Los Angeles, CA, Contact: American Academy of Family Physicians, 1740 W. 92nd Street, Kansas City, MO 64114. (816) 333-9700.

24-27, American Neurological Association, New Orleans, Contact; American Neurological Association, 2221 University Avenue SE, Suite 350, Minneapolis, MN 55414. (612) 378-3290.

24-28, American Academy of Otolaryngology — Head and Neck Surgery Annual Scientific Meeting, New Orleans, LA, Contact: American Academy of Otolaryngology — Head and Neck Surgery, 1101 Vermont Avenue, N.W., Suite 302, Washington, DC 20005. (202) 239-4607.

October

11-15, American Academy of Child and Adolescent Psychiatry, New York, NY, Contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue NW, Washington, DC 20016. (202) 966-7300.

14-18, American Society of Anesthesiologists Annual Meeting, New Orleans, LA, Contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068. (312) 825-5586.

15-20, American College of Surgeons Annual Scientific Meeting, Atlanta Hilton and Towers, Atlanta, GA, Contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611. (312) 664-4050.

19-22, American Society of Internal Medicine Annual Meeting, J.W. Marriott, Washington, DC, Contact: American Society of Internal Medicine, 1101 Vermont Avenue, N.W., Suite 500, Washington, DC 20005. (202) 289-1700.

21-25, American College of Gastroenterology Scientific Meeting, Marriott Hotel, New Orleans, LA, Contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944. (617) 927-8330.

21-26, American Academy of Pediatrics Annual Meeting, Chicago, IL, Contact: American Academy of Pediatrics, 141 Northwest Point Road, P. O. Box 927, Elk Grove Village, IL 60007. (312) 288-5005.

28-11/3, American Society of Clinical Pathologists Annual Scientific Meeting, Ramada Renissiance, Washington, DC, Contact: American Society of Clinical Pathologists, 2100 W. Harrison Street, Chicago, IL 60612. (312) 738-1336.

28-11/3, College of American Pathologists Annual Scientific Meeting, Washington Ramada, Washington, DC, Contact; College of American Pathologists, 5202 Old Orchard Road, Skokie, IL 60077 (312) 966-5700.

29-11/2, American Academy of Ophthalmology Annual Meeting, Convention Center, New Orleans, LA, Contact: American Academy of Ophthalmology, P. O. Box 7424, 655 Beach, San Francisco, CA 94120 (415) 561-8500.

29-11/3, American Society of Plastic and reconstructive Surgeons Annual Scientific Meeting, San Francisco Hiltion, San Francisco, CA, Contact: American Society of Plastic and Reconstructive Surgeons, 233 N. Michigan 29-11/4, Congress of Neurological Surgeons Annual Meeting, Atlanta, GA, Contact: Congress of Neurological Surgeons, University of Southern California, 1200 N. State Street, Los Angeles, CA 90033. (213) 226-7421.

30-11/3, American Academy of Occupational Medicine Interim Meeting, Sheraton Inner Harbor, Baltimore, MD, Contact: American Academy of Occupational Medicine, 2340 S. Arlington Heights Road, Suite

MEETINGS

400, Arlington Heights, IL 60005. (312) 228-6850.

November

3-4, American Academy of Pain Medicine, 1989 Annual Conference, Dallas, TX, Contact: American Academy of Pain Medicine, 43 East Ohio #914, Chicago, IL 60611. (312) 645-0083.

5-10, American Academy of Physical Medicine and Rehabilitation, Convention Center, San Antonio, TX, Contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603-6107. (312) 922-9366.

11-15, American College of Allergy and Immunology, Orlando, FL, Contact: American College of Allergy and Immunology, 800 E. Northwest Highway #1080, Palatine, IL 60067. (312) 359-2800.

13-16, American Heart Association, New Orleans, LA, Contact: American Heart Association, 7320 Greenville Avenue, Dallas, TX 75231. (214) 706-1483.

December

2-5, American Society of Hematology, Atlanta, GA, Contact: American Society of Hematology, 6900 Grove Road, Thorofare, NJ 08086. (609) 845-0003.

2-7, American Academy of Dermatology Annual Meeting, San Francisco, CA, Contact: American Academy of Dermatology, 1567 Maple Avenue, P. O. Box 3116, Evanston, IL 60204-3116. (312) 869-3954.

Other Meetings

June

24, Organizational Meeting for the U. P. Chapter of Graduates of Foreign Medical Schools (GFMS), Conference Center, Out-Patient Clinic Bldg., Marquette General Hospital. Contact: Satish Shah, MD, 420 W. Magnetic St., Marquette, Michigan 49855. (906) 225-3102.

September

11-13, Treatment of Destructive Behaviors in Persons with Developmental Disabilities, Warren Grant Magnuson Clinical Center, Bethesda, Maryland 20852 (301) 468-6555.

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PRESIDENT'S PAGE

Socialized Medicine Are We Ready for It?

By Robert E. Paxton, MD

In May when I was elected president, a colleague of mine congratulated me and said that I must feel important. Interestingly enough, my gut reaction and immediate response was, "No, I just feel a great sense of responsibility."

Of course, the inaugural ceremony and the warm response from the House of Delegates does put one on an ego trip. There is no denying that! But as the leader of this great medical society, I pledge to advance the noble purposes of MSMS and to enhance both its services and image. Add to this the mandate to promote quality health care for the citizens of this state, and you shoulder a tremendous responsibility — a responsibility that requires considerable dedication and sacrifice.

On the surface, this appears awesome and perhaps overwhelming, but it is a spirit shared by a dedicated staff and energetic leadership from across the state. In addition, one of my goals is to increase grass roots participation in MSMS activities. With unity in purpose and involvement by all, the goals become attainable.

An illustration of this responsibility is a complex problem facing, not only our profession, but all of America. A problem that evolves from current priorities in this country which severely limit resources for the health care of this nation. For all of us, this raises a concern about quality and access, but for the uninsured, it becomes a crisis!

Cost containment activity stressing only economics and the ultimate, blatant rationing of care in the offing are matters of great concern to the profession. Out of this apparent chaos comes the cry for a solution! And we wake up to find that the answer is voiced all about us — socialized medicine!

Historically, this cry surfaced in the early 1930's during the great depression when there was a shift in emphasis to a strong, central government to deal with the socioeconomic plight of the country. The AMA, through its efforts and the influence of Doctor Cushing on President Roosevelt, prevented socialized medicine, and our traditional, pluralistic medical care system endured.

Since that time, there has been only token mention of a National Health Service, until Senator Ted Kennedy's efforts in the early '80s. His endeavors were soon discarded because of the program's cost in the face of an ever-increasing national debt. Now suddenly, we face perhaps the most serious threat of socialized medicine then ever encountered before. A bill, cosponsored by Senator Kennedy and Representative Waxman, has been introduced which will phase in complete nationalization of health care by the year 2000.

The interesting fact is that the cry for socialized medicine is not necessarily coming from the far left of the political spectrum. Rather, it is being heard from the stalwart supporters of free enterprise — big business! Joining in the clamor are concerned physicians who rally together under the banner, PNHP — Physicians for a National Health Program.

Why do some physicians support a national health program? They decry the plight of the uninsured, the limited access to care and the bureaucratic cost of our present system. They see health dollars go down the drain in billing procedures, eligibility determination and marketing activity, they are rankled by cost containment activity with patchwork, band-aid solutions. They put the blame squarely on the insurance companies and plead for a Canadian type of system in our country.

MSMS has to deal with the situation head-on. I believe that, first of all, we should acknowledge that although we have a great medical system, there are flaws and problems which need to be addressed.

Cost, limited access and rationing already are problems for us. Although we talk about these flaws in generalized, impersonal terms, let's develop a little more feeling in our concern. Pay for a prescription for antibiotics, ulcer drugs or some cholesterol-lowering agents at the local pharmacy. Look at the hospital cost for ribovirin to treat RSV. Open your billfold to pay for a CAT scan or MRI ordered by your physician. I'm not debating the relative value of these drugs or examination. But I maintain that the cost can ration care if you are old and on a fixed income or have limited insurance benefits.

However, recognizing that there is a problem does not go far enough. We must not bury our heads in the sand and simply insist on the status quo. We must thoughtfully listen to the arguments and thoroughly review the proposals. We must protect the public and assume the role of our patients' advocate so that they are not sold a bill of goods.

For the State of Michigan, MSMS has the capability and resources to do all of the above. We have talented and knowledgeable leadership, such as our president-elect Susan Hershberg Adelman, MD. She is not only capable of entering the dialogue, but she is sensitive to the problem. She is backed by an efficient staff at MSMS and is assisted by experienced leaders in the health care arena.

My plea is for the encouragement and backing of the state society as we face the Herculean task of finding an appropriate solution. My appeal to the membership is to realize the problem, study the alternatives and forward to us your arguments and conclusions. ■

Doctor Paxton is MSMS president.

VASOTEC®

(ENALAPRIL MALEATE | MSD)

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor

Warnings: *Angioedema* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms Angioedema associated with laryngeal edema may be fatal **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics. heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy In such patients, renal function should be monitored during the first few weeks of therapy

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC (See *Drug Interactions*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion

Information for Patients:

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure, patients should be advised to consult with the physician.

Hyperkalemia Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted This information is intended to aid in the safe and effective use of this medication It is not a disclosure of all possible adverse or intended effects

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently

Pregnancy—Category C There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapr (333 times the maximum human dose) Fetotoxicity expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline Enalapril was not teratogenic in rabbits However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose)

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters

There are no adequate and well-controlled studies in pregnant women VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate It is not known whether this drug is secreted in human milk Because many drugs are secreted in human milk caution should be exercised when VASOTEC is given to a nursing mother

Pediatric Use Safety and effectiveness in children have not been established

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients

Hypertension The most frequent clinical adverse experiences in controlled trials were headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were. diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%)

Heart Failure. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were. dizziness (79%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%)

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%)

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category

Cardiovascular: Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation

Digestive Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy

Respiratory Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity

Other. Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia, an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur These symptoms have disappeared after discontinuation of therapy

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure (See WARNINGS)

Clinical Laboratory Test Findings:

Serum Electrolytes Hyperkalemia (see PRECAUTIONS), hyponatremia

Creatinine, Blood Urea Nitrogen In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists In clinical trials, less than 0.1% of patients discontinued therapy due to anemia

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported

Liver Function Tests. Elevations of liver enzymes and/or serum bilirubin have occurred

Dosage and Administration: *Hypertension* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS)

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily

Heart Failure VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses The maximum daily dose is 40 mg Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg

For more detailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486

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